ASSESSMENT OF THE EFFECTS OF INTERPERSONAL OPENNESS AND COPING RESOURCES ON THE PSYCHOLOGICAL SEQUELAE OF TRAUMATIC VICTIMIZATION

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The present study tested a model addressing whether interpersonal Openness and interpersonal and intrapersonal Coping Resources mediated the relationship between interpersonal Victimization and the Psychological Symptoms women experience as a result of these traumas. Victimization indicators (physical violence, sexual assault, psychological abuse, and revictimization), Coping indicators (optimism, self-esteem, private self-consciousness, social network and therapy), Openness indicators (self-silencing, communal orientation, trust, self-monitoring, and network orientation), and Psychological Symptoms indicators (global distress, dissociation, and suicidal ideation) were examined separately for African American (n = 245), Euro-American (n = 185), and Mexican American (n = 202) women. Structural Equation Modeling revealed that for African American and Euro-American women, Openness partially mediated the victimization-distress relationship. The model for Mexican Americans was the most complex with Openness and intrapersonal Coping fully mediating the psychological effects of victimization. Approximately 50% of the variance in psychological symptoms resulting from victimization was predicted by this model for African American and Euro-American women; over 80% of the variance was predicted for Mexican Americans. Thus, the importance of Openness to relationships in alleviating the psychological sequelae

following interpersonal victimization was underscored by the results. Similarities and differences between these models are discussed. Implications of the results for future research and intervention are addressed.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

CHAPTER I

LITERATURE REVIEW

A great deal of research addresses women sustaining violence in their families of origin (Breslin, Riggs, O'Leary, & Arias, 1990; Cappell & Heiner, 1990; O'Keefe, 1998; Simons, Lin, & Gordon, 1998; Steinmetz, 1977) and from dating (Bernard & Bernard, 1983; Breslin, et al., 1990; O'Keefe, 1998; Simons, et al., 1998), cohabiting (Rennison & Welchans, 2000; Straus & Gelles, 1990; Straus, Gelles, & Steinmetz, 1980), and marital partners (Gelles, 1993; Hotaling & Sugarman, 1986; Stark, Flitcraft, Zuckerman, Grey, Robinson, & Frazier, 1981; Straus & Gelles, 1990; Straus, et al., 1980). Until the past decade, there was little cross-fertilization of research and theory across these types of relationships. Similarly, bodies of research on sexual assault perpetrated by strangers (Hammock, & Richardson, 1997; Renner, & Wackett, 1987), dates (Bergen, 1995; Vicary, Klingaman, & Harkness, 1995), and romantic partners (Bergen, 1995; Monson, Byrd, & Langhinrichsen-Rohling, 1996) now are beginning to be integrated (Browne, 1993b). Psychological abuse, another type of harmful behavior inflicted in relationships, has also had little cross-fertilization across types of relationships. With few exceptions (e.g., Goodman, Koss, Fitzgerald, & Russo, 1993), what is lacking is the recognition that these bodies of research share the common theme of victimization, and psychological and emotional symptoms. An ethnically diverse sample of community women was used to test a model in which the effects of victimization on emotional distress would be mediated by women's coping resources and openness.

The psychological impact of victimization is similar across types of assault (e.g., Banyard, 1997; Hampton, Jenkins, & Vandergriff-Avery, 1999; Milner & Crouch, 1999; Murphy & Cascardi, 1999; Riggs, Kilpatrick, & Resnick, 1992; Weisaeth & Eitinger, 1993). This suggests that symptomology maybe relatively independent of the specific act. However, the coping resources available to women likely mediate the victim-symptom relationship. In addition, openness appears to underlie many coping resources. As openness to relationships is also likely to be affected by victimization, it may function to mediate the relationship between victimization and coping. These aspects of the model are described as is the moderating influence of socioeconomic status and ethnicity.

Before describing the victimization literature, terminology should be clarified. For present purposes, violence consists of physical acts with the potential to cause physical injury to the recipient. In addition to sexual intercourse with a nonconsenting adult (i.e., the traditional definition of rape or sexual assault), the term sexual aggression is used to include touching or fondling, oral and anal sexual acts, and other sexual acts that are initiated through coercion, threats, and acts of violence by acquaintances or intimate partners (Koss, 1998). Sexual assault refers to those same acts inflicted by a nonpartner. Marshall (1994) argued that previous definitions of psychological abuse, including threats of violence and/or other overtly dominating and controlling acts by a partner (e.g., Murphy & Cascardi, 1993; Mason & Blankenship, 1987; Follingstad, Rutledge, Berg, Hause, & Polek, 1990; Murphy & Hoover, 1999; Stets & Pirog-Good, 1990; Tolman, 1989, 1999), were too limiting and did not capture the variety of overt and subtle acts that may harm women. Consequently, the term psychological abuse denotes acts targeting

perceptions, thoughts, feelings, or behavior that may have profound effects on how women view themselves, their partner, their relationships, and others (Marshall, 1999).

Victimization

The prevalence rates for sustained family of origin violence, intimate partner violence and sexual aggression, psychological abuse, and sexual assault vary due to the use of different samples and measures. Sociocultural and socioeconomic factors also impact prevalence. Furthermore, the notable crossover between sustaining different forms of interpersonal victimization has led to the emergence of research on revictimization, the recurrence of assault. Although the rates vary across studies, the psychological importance of all types of victimization is quite similar.

Family of Origin

An important distinction in family of origin violence is whether a woman was abused as a child or witnessed violence between her parents (Kalmuss, 1984; Marshall & Rose, 1988; Pagelow, 1981). Sustained violence in childhood may be more psychologically and emotionally harmful than that which is witnessed (Sternberg et al., 1993). Only violence women sustained from parents is addressed to study the effects of direct victimization.

The National Center on Child Abuse and Neglect (1988) estimated there are more than 1 million reports of child abuse and neglect each year. However, this figure likely understates actual incidents (Blau & Long, 1999; Emery, 1989). Approximately 3 million children were reported to Child Protective Services in the 50 states in 1995, about one third of whom were substantiated as victims of maltreatment (Lung & Daro, 1996).

Approximately 25% of these cases were for physical abuse. A Gallup poll found that 5% of children were physically abused in the previous year (Gallup, Moore, & Schussel, 1995). Population surveys yield higher estimates. If spanking is included, an estimated two thirds of children are victims of violence (e.g., Finkelhor & Dziuba-Leatherman, 1994). Two national surveys (Straus & Gelles, 1986, 1990; Straus, et al., 1980) found that 62% to 63% of children between the ages of 3 and 17 sustained an act of violence by a parent each year. Overall, incidence rates may be misleading. In the 1975 survey, 97% of 3 year olds sustained parental violence. For children 15 and older, 33% were hit by a parent. In 1975, almost 4% and in 1985 almost 2% of children experienced an assault sufficiently serious to be included in the "Very Severe Violence Index." Thus, physical aggression by parent is a prevalent form of victimization.

Many studies have addressed the negative emotional and psychological impact of family of origin violence on adults. Sustained parental violence has been found to result in an increase in anxiety (Egeland, Sroufe, & Erickson, 1983), hypervigilance (Egeland et al., 1983; Kaufman & Cicchetti, 1989), global distress (Egeland et al., 1983; Kaufman & Cicchetti, 1989), suspicion (Egeland, et al., 1983; Martin & Elmer, 1992), and intrusive thoughts (Egeland et al., 1983). Other studies have found family of origin violence also resulted in depression, sleep disturbance, and suicidal feelings (Famularo, Fenton, Kinscherff, Ayoub & Barnum, 1994; Famularo, Kinscherff, & Fenton, 1992; Herman, 1992; Kiser, Heston, Millsap, & Pruitt, 1991; Livingston, Lawson, & Jones, 1993; Malinosky-Rummell & Hansen, 1993). In the literature, violence by parents appears to be

a type of victimization directly related to the development of psychological symptoms that may remain in adulthood.

Romantic Relationships

The estimated incidence for women sustaining violence by an intimate partner range from 0.9% (Bachman & Saltzman, 1995) to 22% (Meredith, Abbott, & Adams, 1986). The two national surveys of family violence (Straus, et al., 1980; Straus & Gelles, 1986, 1990) found that 12% of married or cohabiting couples in 1975 and 11% of couples in 1985 had at least one act of violence during the previous year. The Commonwealth Fund survey showed an 8% incidence for any violence and 3.2% for severe violence against women in the prior year (Plichta, 1996). However, O'Leary (1988) argued that an act of physical violence occurs in at least half of all relationships, with higher rates among couples who seek therapy. Epidemiological data have revealed that 21% to 34% of all women are physically assaulted by an intimate partner during their adult lives (Browne, 1993a). Rennison and Welchans (2000), using the National Crime Victimization Survey (NCVS), found that 25% of female participants had been physically assaulted and/or raped by their current or former spouse, cohabiting partner or boyfriend. A substantial proportion of dating relationships also include violent encounters. The results of studies have ranged from 9% to 66%, with most studies finding approximately 30% of undergraduates reporting dating violence (Clark, Beckett, Wells, & Dungee-Anderson, 1994; Laner & Thompson, 1982; Römkens & Mastenbroek, 1998; Sugarman & Hotaling, 1989; White & Koss, 1991).

A great many studies have shown that partner physical violence often leads to anxiety, depression, intrusive and recurrent memories or thoughts, simple phobias, agoraphobia, sleeping difficulties, and various somatic complaints (Astin, Lawrence, & Foy, 1993; Gleason, 1993; Herman, 1992; Plichta, 1996; Rasche, 1988; Riggs, Kilpatrick, & Resnick, 1992; Saunders, 1994; Scott-Gilba, Minne, & Mezey, 1995; Vogel & Marshall, 2000; Walker, 1984; Walker & Browne, 1985). Suicidal ideation (Kaslow et al., 1998; Scott-Gilba et al., 1995) has also been linked to partner violence. Furthermore, the physical injuries women sustain (e.g., broken bones, burns, scars) may, in turn, cause or exacerbate psychological symptoms. The negative emotional impact of violence does not appear limited to any specific cultural or economic group. For example, Bassuk, Browne, and Buckner (1996) found that 91.6% of homeless and 81.8% of housed women on welfare reported physical or sexual assaults during their life that they believed caused emotional problems. Kaslow et al., (1998) found that African American women who attempted suicide were more likely to have been victims of physical and psychological partner victimization than were demographically similar women who had not attempted suicide. Thus, the negative impact of partner violence can be severe.

Psychological Abuse

Psychological abuse is perhaps the most difficult form of interpersonal aggression to assess due to difficulty arriving at a common definition, the variety of terms used, the strong correlation with threats of violence and verbal abuse, and examination only in conjunction with physical violence (Follingstad, Rutledge, Berg, Hause, & Polek, 1990; Gondolf, 1985; Marshall, 1994; Mason & Blankenship, 1987; Murphy & Cascardi, 1993;

Okun, 1986; O'Leary, 1999; Stets & Pirog-Good, 1990; Tolman, 1989, 1992). In addition, many studies have used clinical samples rather than dating or community samples because of the connection with battering. Despite these obstacles, prevalence from a representative sample of households indicated that psychologically abusive behaviors, defined as threats, verbal, and symbolic (e.g., stomping) aggression, occur in approximately 75% of the households (Straus & Sweet, 1992). Barling, O'Leary, Jouriles, Vivian, and MacEwen (1987) found that among distressed partners seeking marital counseling, 89% to 97% had engaged in these behaviors during the preceding year. These higher rates found among distressed couples are consistent with the results from dating and engaged samples (O'Leary, Barling, Arias, Rosenbaum, Malone, & Tyree, 1989; Sugarman & Hotaling, 1989). A sample of never married adult Canadian women, Johnson and Sacco (1995) found a much lower 17% rate, while Pipes and Lebov-Keeler (1997) found 11% of female college students reported these types of psychological abuse.

Almost all women who sustain violence also report sustaining verbal (Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Walker, 1984) or psychological (Bergen, 1995; Follingstad et al., 1990; Tolman, 1989) abuse. Women in physically violent relationships reported more psychological abuse than those in either dissatisfied but nonviolent or satisfied relationships (Carbone, 1996; Tolman, 1999). A longitudinal study of newlyweds showed that psychological aggression predicted the initiation and frequency of physical violence (Murphy & O'Leary, 1989; O'Leary, Malone, & Tyree, 1994). However, Marshall (1999) found only moderate to low correlations between

psychological abuse and physical violence or sexual aggression by women's partners in a community sample. Threats of violence were not included in Marshall's study, which may account for the differences. She defined psychological abuse more broadly as including both subtle and overt acts that may harm women psychologically and emotionally. Subtle acts, although not evident to the target or others, may be as harmful as overt acts readily identified as abusive or aggressive (Marshall, 1994, 1996).

There is little research on the emotional consequences of psychological abuse (Murphy & Cascardi, 1999), but it has been shown to harm women's health (Arias, Street, & Brody, 1996; Cascardi & O'Leary, 1992; Dutton & Painter, 1993; Houskamp & Foy, 1991; Murphy & Cascardi, 1999; Saunders, 1994; Walker, 1984). Psychological abuse results in fear (Marshall, 1999; Murphy & Cascardi, 1999; Saunders, 1994), PTSD (Arias, 1995; Cascardi, O'Leary & Schlee, 1997; Houskamp & Foy, 1991; Kemp, Green, Hovanitz, & Rawlings, 1995; Murphy & Cascardi, 1999; Saunders, 1994; Vitanza, Vogel & Marshall, 1995), global distress (Vitanza, Vogel & Marshall, 1995) depression (Cascardi et al., 1997; Marshall, 1999; Murphy & Cascardi, 1999), suicidal ideation (Marshall, 1999; Murphy & Cascardi, 1999; Saunders, 1994; Vitanza et al., 1995), anxiety disorders (Murphy & Cascardi, 1999; Saunders, 1994), intrusive thoughts (Cascardi et al., 1997; Houskamp & Foy, 1991; Kemp, Green, Hovanitz, & Rawlings, 1995; Murphy & Cascardi, 1999; Saunders, 1994; Vitanza et al., 1995) and social isolation (Cascardi et al., 1997; Houskamp & Foy, 1991; Kemp, Green, Hovanitz, & Rawlings, 1995; Marshall, 1999; Murphy & Cascardi, 1999; Saunders, 1994). Psychological abuse may exert more profound psychological effects than partner violence

(Marshall, 1999; Walker, 1984). For example, 72% of the community women who sustained physical violence reported that the psychological abuse had a more severe impact (Follingstad et al., 1990). Among low-income community women, Marshall (1999) found that subtle psychological abuse had stronger and more consistent negative effects on women's emotional states (self-esteem, stress, overall distress, severe depression, and suicidal ideation) than did their partners' overt psychological abuse, violence, or sexual aggression. Two studies found that more than half of their samples who sustained psychological abuse met criteria for PTSD (Kemp, Green, Hovanitz & Rawlings, 1995; Vitanza et al, 1995). Thus, despite the relative lack of research, this form of victimization has negative emotional and psychological consequences.

Sexual Assault

The prevalence of rape also varies across studies. Most estimates range from 2% to 50% of women (Hall & Flanery, 1984; Harris, 1993; Kilpatrick, Saunders, Veronen, Best, Von, 1987; Koss, 1992a; Koss & Oros, 1982; Moore, Nord, & Peterson, 1989; Riger & Gordon, 1981). Epidemiological studies show that 25% to 50% of women have been sexually assaulted (Kilpatrick et al., 1987; Koss & Dinero, 1989; Spitzberg, 1999) with 5.3% (Siegel, Sorenson, Golding, Burman, & Stein, 1987) to 27% (Finkelhor, 1994) up to 62% (Wyatt, 1985) reporting sexual molestation during childhood. Among participants in the National Crime Victimization Survey (Tjaden & Thoennes, 1998), 17.6% sustained an attempted (2.8%) or completed (14.8%) rape. In his review of 120 studies over 40 years, Spitzberg (1999) found a prevalence of 13% when rape was defined as penile-vaginal penetration through the use or threat of force. The prevalence of

sexual assault by various means, including the use of penis, tongue and/or objects to penetrate the orifices (oral, anal, vaginal) through force or threat of force, was 22%.

The prevalence of sexual assault by perpetrator identity has also been addressed. These rates have ranged from 8% to 31% for strangers (Stermac, Du Mont, & Dunn, 1998; Vicary, Klingaman, & Harkness, 1995), 35% to 53% for acquaintances (Craven, 1997; DiVasto, 1984; Koss, Gidycz, & Wisniewsky, 1987), 14% to 23% for dates (Rubenzahl & Corcoran, 1998; Spitzberg, 1999; Vicary et al., 1995), and 10% to 36% for spouses (Bachman & Saltzman, 1995; Hanneke, Shields, & McCall, 1988; Hoffman & Toner, 1989; Mahoney & Williams, 1998; Resnick, Kilpatrick, Walsh, & Vernonen, 1991; Russell, 1990; Statistics Canada, 1993).

The psychological symptoms experienced by victims of both adult and childhood sexual assault include dissociation (Briere, 1992a, 1992b), global distress (Burnam, et al., 1988; Jumper, 1995; Kilpatrick, Veronen & Resick, 1979), depression (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Briere, 1992a, 1992b; Burnam, et al., 1988; Chandler & Jackson, 1997; Jumper, 1995), isolation (Briere, 1992a, 1992b; Chandler & Jackson, 1997; Zweig, Barber & Eccles, 1997), paranoia (Briere, 1992a, 1992b; Burnam, et al., 1988; Kilpatrick et al., 1979; Kilpatrick & Veronen, 1984), sexual dysfunction (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Briere, 1992a, 1992b), somatization (Briere, 1992a, 1992b; Dvorak & Resick, 1988), and fear and anxiety (Briere, 1992a, 1992b; Burnam, et al., 1988; Kilpatrick et al., 1979; Kilpatrick & Veronen, 1984). Victims of sexual assault or physical violence are likely to report suicidal ideation and attempts (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991;

Briere, 1992a, 1992b; Dutton, 1992a, 1992b; Ellis, Atkeson, & Calhoun, 1981; Frank, et al., 1979; Frank & Stewart, 1984; Herman, 1992; Hampton, Jenkins, & Vandergriff-Avery, 1999; Hilberman & Johnson, 1978; Hilberman, 1980; Kilpatrick et al., 1985; Kaplan, Asnis, Lipschitz, & Chorney, 1995; McGrath et al., 1990; Resick et al., 1988; Roberts, Lawrence, O'Toole, & Raphael, 1997; Stark & Flitcraft, 1988; 1996; Straus & Gelles, 1990), regardless of ethnicity (Marshall, 1999). Kilpatrick et al. (1989) found that rape victims who sustained physical injury and perceived life threat were 8.5 times more likely to develop an anxiety disorder than when raped without these elements. Kilpatrick et al. (1985) found that 19% of rape victims in a community sample reported suicide attempts as opposed to only 2% in a nonvictimized group. Furthermore, Ellis and colleagues (1981) found that 50% of women reporting on sexual assaults they sustained one to 16 years earlier had contemplated suicide. Russell, Schurman, and Trocki (1988) found that African American women, as a result of incest, reported more upset, greater long-term effects and more negative life experiences that Euro-American victims. Wyatt (1990b) suggested the effects of sexual victimization may be compounded for African Americans as a result of racism. These data clearly illustrate the negative emotional impact of sexual assault and the potentially moderating effect of ethnicity on psychological symptoms following sexual aggression.

Revictimization

Interpersonal victimization often is not an isolated event. Women who sustain physical violence, psychological abuse, and sexual assault may be revictimized by the same or different perpetrators**.** Family of origin violence and childhood sexual assault

have been linked to revictimization in adulthood. Furthermore, revictimization across relationships and types of assault also occurs. Thus, it is important to address the prevalence and psychological impact of these forms of interpersonal aggression.

Physical assault sustained from parents during childhood has long been addressed as a possible explanation for the prevalence of intimate violence. The term intergenerational transmission of violence has been used for this well-established link (Bernard & Bernard, 1983; Breslin, Riggs, O'Leary, & Arias, 1990; Cappell & Heiner, 1990; Hotaling & Sugarman, 1986; Kalmuss, 1984; Laner & Thompson, 1982; Malone, Tyree, & O'Leary, 1989; Steinmetz, 1977; Straus et al., 1980). Aldarondo and Kantor's (1997) review of predictors for sustaining partner violence found that women were more likely to be victimized on an ongoing basis when they had sustained severe violence at the hands of their fathers. In studies with battered women, the prevalence of sustained family of origin violence ranges from 23% (Gayford, 1975) to 100% (Rynerson & Fischel, 1993). In the National Crime Victimization Survey, 52% of women had been physically assaulted as a child and as an adult (Rennison & Welchans, 2000). Irwin (1999) found that the severity of childhood victimization predicted proneness to adult violent victimization. Thus, violence sustained as a child may affect the likelihood of revictimization and the coping strategies women use.

The myth of battered women who sustain violent revictimization across intimate relationships has been hypothesized for decades (e.g., Fox et al., 1996; Walker, 1984). Several authors address past and current relationship violence (e.g., Barnhill, Squires, & Gibson, 1982; Gray & Foshee, 1997; Lloyd & Taluc, 1999; Page-Adams & Dersch,

1998) but rarely do they test for an association across partners. When the relationship has been examined, the correlations are small (Weston & Marshall, 1999) or nonexistent (Archer & Ray, 1989).

Several studies have linked childhood sexual assault and sexual revictimization. Wyatt, Guthrie, and Notgrass (1992), Urquiza and Goodlin-Jones (1994), Wyatt and Riederle (1994) and Briere (1992b) all noted that once sexually victimized, the likelihood of revictimization is high. The prevalence of sexual revictimization ranges from 6% to 68% (Atkeson, Calhoun & Morris, 1989; Mandoki & Burkhart, 1989; Marhoefer-Dvorak, Resick, Hutter, & Girelli 1988; Miller et al., 1978; Russell, 1986). In the National Violence Against Women Survey (Tjaden & Thoennes**,** 1998), 18% of female victims who had been sexually assaulted before the age of 18 were also raped thereafter, compared to 9% of women who had not been a young victim. Women raped during the 12 months preceding participation in the survey averaged 2.9 rapes during that year. Over half (56%) of Wyatt, Guthrie, and Notgrass's (1992) female participants who had sustained sexual abuse as a child were sexually revictimized in adulthood. When noncontact abuse was included, revictimization increased to 73%. Urquiza and Goodlin-Jones (1994) showed that among women who had been raped, nearly 65% had also experienced sexual assault prior to age 18. Among women not sexually victimized in adulthood, 35% reported a history of childhood sexual abuse. Further, Mahoney (1999) found that women sustaining marital sexual assault were significantly more likely than those raped by an acquaintance or stranger to experience multiple assaults, often as many as 10 times in a six month period.

Revictimization also occurs across types of assault. Adults who sustained childhood violence and sexual assault are more likely than others to experience later sexual assaults (Cloitre, Tardiff, Marzuk, Leon, & Portera, 1996; Miller, Moeller, Kaufman, Divasto, Fitzsimmons, Pather, & Christy, 1978; Russell, 1986), physical assaults (Goodman & Fallon, 1995; Weaver, Kilpatrick, Resnick, Best, Saunders, 1997), or both (Browne & Finkelhor, 1986a; Herman & Hirschman, 1981; Irwin, 1999; Messman & Long, 1996; Sappington, Pharr, Tunstall, & Rickert, 1997). However, estimates across types of aggression are rare. For example, Herman and Hirschman (1981) reported that 28% of women with a childhood history of incest were later victims of domestic violence. Similarly, Messman and Long (1996) found an association between childhood sexual abuse and an increased probability of adult sexual and physical victimization. Date rape has been associated with a childhood sexual, physical, and psychological victimization (Sappington, Pharr, Tunstall, & Rickett, 1997). Campbell (1989b) found that 40% to 45% of battered women also sustain marital rape. The link between psychological abuse and violence by a partner was noted earlier (Bergen, 1995; Follingstad et al., 1990; Tolman, 1989; Walker, 1984).

The psychological impact of revictimization has been largely ignored partially due to the emphasis on separate types of assault. However, researchers repeated physical or sexual assault, whether by the same or different assailants, compounds the effects and may produce long-term emotional numbing, extreme passivity, helplessness, global distress, and suicidal ideation (Dutton, 1992b; Herman, 1992; van der Kolk, MacFarlane, & Weisaeth, 1996; Walker, 1979, 1984). Adults who sustained physical and sexual child

assaults may have substantial relational problems (Stalker & Davies, 1995) that may lead to revictimization (Carey, 1997) due to poor interpersonal skills (Fernández-Esquer & McCloskey, 1999). Thus, revictimization likely increases the severity of symptoms.

In sum, child abuse, partner violence and psychological abuse, sexual assault, and revictimization are prevalent and pervasive problems for women. Moreover, there are similar psychological and emotional effects (Weisaeth & Eitinger, 1993) for these types of victimization. The symptoms range from somatic manifestations to anxiety to psychotic symptoms. Due to the range and severity of symptoms associated with interpersonal victimization, it is important to address variables that may impact this relationship.

Sociocultural Moderators

Two of the sociocultural influences that have been examined as potentially moderating the psychological impact of victimization are socioeconomic status (SES) and ethnicity. SES has been inversely related to all types of victimization (Aldorando & Kantor, 1997; Bachman & Saltzman, 1995; Bassuk, Browne & Buckner, 1996; Bassuk, & Rosenberg, 1988; Byrne, Resnick, Kilpatrick, Best, & Saunders, 1999; D'Ercole & Struening, 1990; Dubowitz, Hampton, Bithoney, & Newberger, 1987; Ellis, Atkeson, & Calhoun, 1982; Goodman, 1991a; Greenfeld et al., 1998; Kantor & Straus, 1992; Kilpatrick,et al., 1998; Miller et al., 1978; Redmond & Brackmann, 1990; Rennison & Welchans, 2000; Smith & Bennett, 1985; Wood, Valdez, Hayashi, & Shen, 1990; Zuravin, 1989). To date, there is less consensus on the relationship between ethnicity and victimization. One problem is that Mexican Americans are seldom distinguished from

other Hispanics, despite differences among groups descending from different countries and geographical areas (Altarriba & Bauer, 1998; Cafferty & Chestang, 1976; West, Kantor, & Jasinski, 1998).

Socioeconomic Status. Research has addressed the impact of SES on sustained family of origin and partner violence, sexual assault, and revictimization. It appears that economic stress increases and predicts the likelihood of sustained victimization among women.

Low SES has been strongly related to child abuse and neglect (Dubowitz, Hampton, Bithoney, & Newberger, 1987; Zuravin, 1989). For example, sustained childhood physical abuse ranged from 42% to 66% among low income housed and homeless women (Bassuk & Rosenberg, 1988; Bassuk et al., 1996; Goodman, 1991; Redmond & Brackmann, 1990). According to Browne and Bassuk (1997), over 60% of these women had sustained severe family of origin violence which greatly surpasses studies finding rates of approximately 5% (Gallup, Moore, & Schussel, 1995; Lung & Daro, 1996; Sedlak 1981, 1991; Sedlack & Broadhurst, 1996). The high rates in low-income samples match the prevalence found in national samples when minor acts such as spanking are included (Straus et al., 1980; Straus & Gelles, 1986, 1990).

SES has also been associated with partner violence. Among low-income women, the prevalence of sustained partner violence ranges from 33% (Redmond & Brackmann, 1990) to 63% (D'Ercole & Struening, 1990). Bassuk and Rosenberg (1988) and Wood, Valdez, Hayashi, and Shen (1990) found that about twice as many homeless as housed women report partner violence. Bassuk et al. (1996) found that 82% of housed low-

income women reported physical or sexual assaults from a partner. When being pushed, shoved, or slapped fewer than six times were excluded, Bassuk et al. (1996) found that 63% of low-income women were victims of domestic violence with Browne and Bassuk (1997) finding that over 32% had sustained severe physical violence by their current or most recent partner. Aldarondo and Kantor's (1997) review of predictors for partner violence found that women were more likely to be victimized on an ongoing basis when they currently had lower family incomes.

Sexual assault and SES also have been associated. Rates for childhood sexual assault among the homeless range from 31% (D'Ercole & Struening, 1990; Wood et al., 1990) to 42% (Bassuk et al., 1996; Goodman, 1991a). National Crime Victimization Surveys found that women with an annual family income under $10,000 were more likely to have experienced partner violence or sexual assault than those with incomes over $10,000 (Bachman & Saltzman, 1995; Greenfeld et al., 1998). Strickingly, women with the lowest annual household incomes were nearly 7 times more likely to be victimized as women with the highest incomes, and those in rental housing were victimized by intimates at three times the rate of women owning their housing (Rennison & Welchans, 2000). Thus, low SES appears to be a risk factor for sexual victimization.

Revictimization also may be linked to SES. Indicators such as living in poverty and being unemployed were associated with higher rates of revictimization in nationally representative sample of women (Kilpatrick et al., 1998; Smith & Bennett, 1985). Byrne, et al., (1999) found poverty status at Wave 1 was not related to assault history, but women living in poverty at Wave 1 were more likely to report a new physical or sexual

assault than women not living in poverty (7% vs. 4%). Clinical samples of women with a history of multiple sexual assaults have a lower SES than victims of single assault (Ellis, Atkeson, & Calhoun, 1982; Miller, Moeller, Kaufman, DiVasto, Pathak, & Christy, 1978). Furthermore, lower SES was linked to having sustained sexual assaults by two or more perpetrators (Browne and Bassuk, 1997). In sum, a consistent and strong link appears to exist between SES and different types of victimization. Economic hardship has been found to increase family stress, raising the level of volatility and probability of violence in everyday arguments. For example, a husband's unemployment was found to diminish marital quality as a result of economic strain, which in turn predicted hostility toward his wife (Conger, et al., 1990). This association between SES and victimization has made identifying ethnic similarities and differences more difficult because ethnicity and SES are often confounded.

Ethnicity. The literature appears inconclusive with some studies finding ethnic differences in victimization while others do not. When studies address ethnicity, African Americans and/or Hispanics are usually compared to Euro-Americans. Asbury's (1999) review found the number of articles addressing ethnicity has increased since 1993, but consistent patterns have yet to emerge.

The number of relevant studies varies by type of victimization. For example, a few studies of sustained child abuse found higher prevalence among African American and Hispanic children than Euro-Americans (Bolton & Laner, 1986; Spearly & Lauderdale, 1983). Data from different years of the National Crime Victimization Surveys have different results. Bachman and Saltzman (1995) found no ethnic differences

for violence perpetrated by intimates, but Greenfeld and colleagues (1998) found the incidence for African American women higher than Euro-Americans. Rennison and Welchans (2000) also found African American women were victimized by intimate partners at a rate 35% higher than that of Euro-American women and about 2.5 times the rate of women of other groups with no differences between Hispanics and non-Hispanics. Other studies have shown the prevalence of physical violence was higher for African Americans than Euro-Americans (Cazenave & Straus, 1990; Gelles, 1993; Hampton & Gelles, 1994; Sorenson, Upchurch, & Shen 1996; Straus et al., 1980; Straus & Gelles, 1986), but Lockhart (1987) found no significant differences. Hispanics have been found to be at higher (Kantor, Jasinski, & Aldarondo, 1994; Straus & Smith, 1990), similar (Sorenson & Telles, 1991), and lower (Fernández-Esquer & McCloskey, 1999; Sorenson et al., 1996) risk than non-Hispanics. However, Sorenson and Telles (1991) only compared of mild forms of violence (e.g., hitting and throwing things at partner). In contrast, Goodman, Dutton, and Harris (1995) found no ethnic differences for physical violence and sexual assault. In samples from battered women's shelters, African Americans, Euro-Americans, and Hispanics reported experiencing similar severity of abuse (Gondolf, Fisher, & McFerron, 1988) with no significant differences on overall frequency of abuse (O'Keefe, 1994).

The typical confound between SES and ethnicity may be problematic. Lockhart (1987) found no significant differences for violence among African American and Euro-American women across social classes. However, Lockhart and White (1989) and

Lockhart (1991) found that middle-class African American women were more likely than middle-class Euro-Americans to sustain marital violence.

Most studies of dating violence have excluded minority women from analyses due to small numbers (O'Keefe, 1997; Sugarman & Hotaling, 1989). The few studies that included ethnicity found higher (Makepeace, 1987; O'Keefe, 1997; O'Keefe, Brockopp & Chew, 1986), similar (White & Koss, 1991) and lower (Lane & Gwartney-Gibbs, 1985) rates for African Americans compared with Euro-Americans. O'Keefe (1997) reported higher rates among Mexican Americans than Euro-Americans. However, when SES, situational, and contextual variables were controlled, the differences disappeared.

No consistent differences have emerged for sexual assault. One study found Euro-American women three times more likely (15% versus 5%) to report child sexual assault than Hispanics (Campbell & Soeken, 1997). Wyatt (1985) reported that as many as 40% of African American community women reported contact sexual abuse before age 18. Urquiza and Goodlin-Jones (1994) found rates of childhood sexual abuse were similar for Euro-American and African American women and lower for Mexican Americans. Similarly, Mennen (1993) found that women in these ethnic groups were similar regarding the severity and acts of sexual abuse they sustained during childhood.

Marsh (1993) found that African American women were victims of sexual assault and physical violence in higher proportions than other ethnic groups. The prevalence of rape or attempted rape in adulthood among African American community women has ranged from 25% (Wyatt, 1992) and 40% (Russell, 1984). Campbell and Soeken (1997) found that more African Americans (50%) than non-African Americans (31%), primarily

Euro-American women, were sexually assaulted by their physically violent partner. Wyatt, Newcombe, and Riederle (1993) also found African Americans at greater risk for sexual assault than Euro-American women, but Wyatt (1992) and George, Winfield, and Blazer (1992) found little difference between these groups. Other studies also found no differences in the prevalence of child and adult sexual assault between these two groups (Bachman & Saltzman, 1995; Russell, 1984) with Sorenson, Stein, Siegel, Golding, and Burnam (1987) finding more Euro-American (26%) than Hispanic women reporting sexual assault.

Revictimization may also be influenced by ethnicity. Interestingly, this body of literature has ignored Mexican Americans and has focused on sexual assault. Both African American and Euro-American women were likely to be sexually revictimized if they had been sexually assaulted before age 18 (Wyatt, 1985). Because over half (52%) of African American women reported more than one incident of sexual assault during childhood, they appear to be more likely to suffer revictimization prior to adulthood. In addition, Russell et al., (1988) found African Americans more likely to experience the use of force during sexual assaults than Euro-Americans.

Thus, minority status may play a role in increasing the risk for victimization risk but the precise pattern is not yet clear. The emphasis on external stress as a causal factor for family violence has been utilized as an explanation for higher rates in African American families (Coley & Beckett, 1988; Kurz, 1989; Plass & Straus, 1987). There seems to be some consensus that African American men, in particular, live in highly stressful environments and this stress may lead them to be violent in the home (McHugh,

Frieze, & Browne, 1993). Brown-Lee (1987) argued that that the underlying cause for violence in many African American families is the lack of economic resources and opportunities with home being the only safe place to release frustrations. Asbury (1999) also applied this explanation to Mexican Americans because they, also, experience more unemployment and economic stress than Euro-Americans. These arguments suggest social class, rather than ethnicity, may underlie many of the differences.

In sum, the victimization literatures have yet to fully clarify the issues of ethnicity and SES especially among women from community populations rather than those identified by the presence of victimization. According to the U.S. Conference of Mayors (1998), half of African American (50%) and Mexican American (49%) families headed by women live below the federal poverty level, compared to less than 40% of Euro-American families. Consequently, SES should be controlled in order to examine the differences that vary with ethnicity. When this has been done, social and economic factors account for much, if not all, of the apparent ethnic differences found in prior research (Hampton & Gelles, 1994; Hampton, Gelles, & Harrop, 1989; Hampton, Jenkins, & Vandergriff-Avery, 1999). This study addressed the confound by including only low-income women and examining ethnicity as a moderator.

Coping With Victimization

Although most victims apparently experience a variety of psychological symptoms, the severity of those symptoms are likely to vary with women's ability to cope with their experience which is a function of available coping resources and specific strategies associated with these resources. Overall, coping is the manner in which an

individual attempts to minimize the psychological and/or physical pain associated with negative life events (Horowitz & Bordens, 1995) and actions taken to deal with stress (e.g., Billings & Moos, 1981; Folkman & Lazarus, 1980; Pearlin & Schooler, 1978). Coping mediates the victimization-distress relationship. Because coping is viewed as a process that varies from situation to situation (Billings & Moos, 1981; Folkman & Lazarus, 1980; Pearlin & Schooler, 1978), the resources needed would vary with the type of victimization experienced. Some studies have attempted to identify specific strategies used by women (Arata, 1999; Arata & Burkhart, 1998; Bergen, 1995; Frazier & Burnett, 1994; Heron, Twomey, Jacobs, & Kaslow, 1997; Lempert, 1996; Neville & Heppner, 1999; Ornduff & Monahan, 1999; Rabin, Markus, & Voghera, 1999; Regehr, Marziali, & Jansen, 1999; Scott-Gilba, Minne, & Mezey, 1995; Ullman, 1996; Valentiner, Foa, Riggs, Gershuny, 1996). This approach is useful for developing interventions for specific types of victimization but does little to advance the development of theories to account for the victimization-distress relationship across different types of interpersonal violence. A more theoretically useful approach would be to consider intrapersonal and interpersonal resources likely to underlie or guide the use of specific coping strategies.

Coping resources likely guide the choice of strategies that may prevent immediate emotional distress from becoming a chronic psychological symptom. This conceptualization is sufficiently broad to encompass the variety of ways women may handle different types of victimization and the psychological symptoms that follow, yet it is sufficiently narrow to be empirically tested. Some of the critical resources likely to mediate the relationship between victimization and long-term effects are optimism,

private self-consciousness (introspection), self-esteem, and utilization of psychotherapy and women's social support network.

Optimism

Optimism, the inclination to anticipate favorable outcomes for future events, has been addressed as a pervasive perceptual bias (Elster, 1979; Fingarette, 1969; Goleman, 1985; McLaughlin & Rorty, 1988) and a personality characteristic associated with stable positive expectations across domains and settings (Metcalfe, 1998; Scheier & Carver, 1985b). Optimists plan and set goals assuming positive results and do not ruminate on negative and depressive aspects of a situation (Scheier & Carver, 1987). They tend to have a more internal locus of control, higher self-esteem, and less hopelessness, depression, perceived stress, alienation, social anxiety (Metcalfe, 1998; Scheier & Carver, 1985b) with fewer psychological and physical symptoms (e.g., Potter-Efron & Potter-Efron, 1999; Stilley, Miller, Manzetti, Marino, & Keenan, 1999) than individuals low in optimism. Optimists tend to engage in problem focused (Bringham, 1991) and external coping strategies, such as seeking social support (Scheier, Weintraub, & Carver, 1985). Overall, optimism is important to mental health and well-being (Andersson, 1996). As a perceptual bias or as a personality trait, optimism appears to be a positive resource for coping.

However, optimism may have conflicting implications for coping with different types of victimization. With chronic victimization (e.g., repeated child abuse, partner violence, or psychological abuse) optimism may allow women to cope with the acts in ways that put them at risk for revictimization by helping to keep them in these harmful

relationships. The underreporting of violence found in samples from battered women's shelters (Gondolf, 1998b; Merritt-Gray & Judity, 1995), women seeking therapy (Cascardi & Vivian, 1995; Ehrensaft & Vivian, 1995; Langhinrichsen-Rohling & Vivian, 1994; Petretic-Jackson, Pitman, & Jackson, 1996), the community (Hamby & Gray-Little, 1997; Kelly, 1989; Margolin, 1987; Murphy & Cascardi, 1993b; Shupe, Stacey, & Hazlewood, 1987), emergency rooms (Klingbeil & Boyd, 1984) and universities (Stith, Jester, & Bird, 1992) may be partly a function of optimism. When reporting their assaults, women often minimize the frequency, severity, and effects of their partner's violence (Arias & Beach, 1987; Baron & Straus, 1989; Bicehouse & Hawker, 1995; DeKeseredy, 1995; Dunham & Senn, 2000; Dutton, 1986; Ehrensaft & Vivian, 1995; Gamache, 1991; Kelley & Radford, 1996; Shevlin, 1994) or overemphasizing their partners positive behaviors (Marshall, Weston, & Honeycutt, 2000) or perceive their relationship is better after the violence (Gryl, Stith, & Bird, 1991). The strategies reflect an optimistic belief the situation will improve or is not severe. In contrast, some studies show women may over-report their victimization (Aldarondo, 1992; Arias & Beach, 1987; Baron & Straus, 1989; Dutton & Haring, 1999; Jouriles & O'Leary, 1985; Langhinrichsen-Rohling & Vivian, 1994; Morse, 1995; Murphy, 1988; O'Leary & Arias, 1988; Schafer, 1996). These women may become overly focused on the negative effects and have a more difficult time coping with the abuse, perhaps due to being low in optimism. Thus, it may be that optimists adjust to their partners' abuse and women low in optimism may cope less effectively but would be more likely to leave violent men. Either way, optimism seems to be implicated in coping with victimization in relationships.

The implications of optimism for coping with single victimization experiences such as a sexual assault or even revictimization if it consists of discrete events across time are more straightforward. In these situations, women may be able to focus on positive factors associated with their victimization and/or deny the severity of the experience. Thus, optimism may result in fewer psychological symptoms when victimization did not occur in the context of an ongoing relationship. The internal locus of control, ability to refrain from rumination, as well as problem focused and external coping strategies associated with optimism (Scheier, Weintraub, & Carver, 1985) are likely to have different effects depending on the frequency, type, and context of victimization.

Private Self-Consciousness

Private self-consciousness is a tendency to reflect upon and think about hidden aspects of the self that are personal in nature and not easily accessible to others, such as privately held beliefs, values, or motives (Scheier & Carver, 1985a). This operationalization of introspection reflects a reliance on private or internal factors more than public, externally observable factors. Private self-consciousness has been associated with an internal locus of control (Franzoi & Sweeney, 1986). Individuals high in private self-consciousness have been found to be more accurate in reporting their internal states (Scheier, Carver, & Gibbons, 1979), more quickly process information pertaining to themselves (Mueller, 1982), show more persistence in coping with stress (Carver, Blaney, & Scheier, 1979) and decreased psychological symptoms (Scheier & Carver, 1985a) than those low in private self-consciousness. These individuals may be in a better

position to take action in response to stressors than those low in self-consciousness. For example, Mullen and Suls (1982) found that stress predicted the development of illness when individuals were low but not high in private self-consciousness. Private self-consciousness may be a coping resource that mediates the relationship between the impact and psychological consequences of stressors (Scheier & Carver, 1985a) such as victimization. Through introspection, women may implement a range of coping strategies or implement strategies more rapidly, resulting in a decrease in the impact of victimization. Thus, private self-consciousness may be an important coping resource.

To the degree that private self-consciousness facilitates cognitive processing of negative events in a way to gain understanding, it could help women cope with victimization. Several authors have addressed the positive impact of writing about a trauma on physical (Donnelly & Murray, 1991; Francis & Pennebaker, 1992; Greenburg & Stone, 1992; Murray, Lamnin & Carver, 1989; Pennebaker & Beall, 1986; Pennebaker, Kiecolt-Glaser & Glaser, 1988; Pennebaker, Mayne, & Francis, 1997; Petrie, Booth, Pennebaker, Davison, & Thomas, 1995) and mental (Esterling, L'Abate, Murray, & Pennebaker, 1999; Harvey, Orbuch, Chwalisz, & Garwood, 1991; Herman, 1992; Spera, Buhrfeind, & Pennebaker, 1994) health. The mechanism through which these beneficial effects occur has been linked to gaining insight (Esterling et al., 1999) and reconceptualizing an event in a manner that facilitates understanding of why it happened, the potential long-term effects, and its value (Harvey, Orbuch, Chwalisz, & Garwood, 1991). The introspection associated with private self-consciousness may facilitate this type of processing whether written or not.

One implication of private self-consciousness for victimization may be that it could facilitate a search for meaning. Through introspection and reflection upon thoughts and feelings about an assault, a woman may reconsider the event, thereby creating a sense of purpose for why it happened and the potential value of the experience. Frieze and Browne (1989) and Follingstad, Neckerman, and Vombrock (1988) suggested that women who sustain partner violence engage in cognitive reappraisal, often by searching for meaning in the adversity, which could result in a decrease in their psychological symptoms. Similarly, Shengold (1989) reported that having sustained childhood victimization such as sexual abuse can strengthen an individual through the pursuit of meaning. Thus, whether victimization is a discrete event or chronic, the processing of personal information associated with private self-consciousness facilitates the use of coping strategies that would allow women to resolve their experience and decrease their psychological distress. Women high in private self-consciousness may be able to avoid victimization or revictimization by cognitively analyzing situations, developing and implementing better coping solutions, and making appropriate choices regarding their safety. Further, the ability to rapidly process information relevant to the self associated with private self-consciousness (Mueller, 1982), may allow women to more effectively weigh alternative strategies in situations with a potential for violence, psychological abuse, or sexual victimization. Logic would suggest these women may more effectively prevent or diminish the severity of victimization than women low in private self-consciousness. Thus, despite the lack of research directly assessing the impact of private

self-consciousness on sustained interpersonal aggression, it appears to be an effective coping resource for dealing with victimization.

Self-Esteem

Self-esteem has been described as a predictor of behavior, a cue to how others react to us, and a fundamental human motive (Baumeister & Leary, 1995; Gray-Little & Hafdahl, 2000; Maslow, 1970). This global self-regard (Porter & Washington, 1979, 1989) or overall judgment of personal worth is related to psychological well-being (Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995) and several aspects of mental health (Dahl, 1992; Kopp & Ruzicka, 1993; Long, 1991; Miller, Moen, & Dempster-McClain, 1991; Pugliesi, 1989; Ryff, 1989; Webster, 1990; Zuckerman, 1989). Individuals high in self-esteem are more likely to utilize social support, a positive coping strategy, to deal with stress (Dolgin, Meyer, & Schwartz, 1991; Papini, Farmer, Clark, & Micka, 1990; Vera & Betz, 1992). Studies have conceptualized self-esteem as a measure of strength for battered women as important to consider as the deficits and problems (Campbell & Humphreys, 1993; Gondolf, 1998c).

Unlike other aspects of coping, self-esteem has been extensively examined in the victimization literatures. Some research on sustained family of origin violence found no relationship with self-esteem (Hibbard, Spence, Tzeng, Zollinger, & Orr, 1992; Kinnard, 1980; Simmons & Weinman, 1991), but other studies found lower self-esteem among children, adolescent, student, and adult samples (Briere & Runtz, 1990a; Conger, 1992; Kazdin, Moser, Colbus, & Bell, 1985; Oates, Forrest, & Peacock, 1985; Silvern, et al., 1995; Stiffman, 1989; Wind & Silvern, 1992). The differences may be a result of the

measures utilized, the severity of victimization sustained, the type of sample, or the time between the assault and the study may have allowed rebuilding of self-esteem. Downs and Miller (1998) found that father-to-daughter verbal aggression and violence decreased women's self-esteem in adulthood. Researchers have consistently found low self-esteem in clinical samples of battered women (Aguilar & Nightengale, 1994; Frisch & MacKenzie, 1991; Mitchell & Hodson, 1983; Sackett & Saunders, 1999; Trimpey, 1989; Walker, 1984). Cascardi and O'Leary (1992) found that as the frequency, severity, and consequences of partners' violence increased, women's self-esteem decreased. Clinical accounts (Aguilar & Nightingale, 1994; Cascardi & O'Leary, 1992; Kasian & Painter, 1992; Lynch & Graham-Bermann, 2000; Nicarthy, 1986; Sackett & Saunders, 1999; Tuel & Russell, 1998; Walker, 1979, 1984) and research with community women (Marshall, 1999) have shown how psychological abuse can erode self-esteem and create confusion and self-doubt.

Studies have found that child sexual abuse was also associated with low self-esteem in adulthood (Bagley & Young, 1990; Briere, 1989; Browne & Finkelhor, 1986b) and the association may be stronger with revictimization (Pantle & Oegema, 1990). Low self-esteem was also related to sexual coercion (Testa & Dermen, 1999) and aggression by dating partners (Pirog-Good, 1992). Rape negatively impacts women's self-esteem shortly after the assault (Atkeson, Calhoun, Resick, & Ellis, 1982; Calhoun, Atkeson, Resick, & Ellis, 1982; Resick, 1986) as well as months to years later (Atkeson et al., 1982; Brandt, 1989; Calhoun et al., 1982; Resick, 1988). Sexually assaulted women may develop a diminished sense of efficacy, low self-esteem, self-blame, shame, guilt, and

unmet needs for attention and approval, all potential cues for vulnerability to sexual offenders perhaps resulting in revictimization (Herman & Hirchman, 1981).

Psychotherapy

The healing effect of therapy has been well documented (Greenberg, 1981; Jacobson, & Martin, 1976; Lipsey & Wilson, 1993; Lyons & Woods, 1991; Seligman, 1995; Whitehead, 1979). Therapeutic interventions, whether based in behavioral, cognitive, existential-humanistic, or psychodynamic theories, assist individuals in developing and implementing functional coping strategies. In addition, psychotherapy may increase other aspects of coping such as self-esteem, and private self-consciousness. The efficacy of psychotherapy in decreasing the psychological symptoms associated with victimization shows it to be a positive resource for coping with victimization.

Freize, Knoble, Washburn, & Zomnir (1980) found that 42% of battered women sought psychological help to address their vicitmization. Several studies have demonstrated the efficacy of psychotherapy in helping individuals cope with interpersonal violence (Bonanno & Kaltman, 2000; Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999; VanFleet, Lilly, & Kaduson, 1999). Foa, et al. (1999) found that therapy decreased depression, post-trauma symptomology, and anxiety and improved global social adjustment in women who had sustained partner violence, regardless of the type of therapy used.

Therapy seems to be effective with survivors of sexual assault as well. Group therapy following sexual assault has been found to improve women's self-esteem, trauma-related symptoms, depression, and coping strategies (Carver, Stalker, Stewart, &

Abraham, 1989; Hazzard, Rogers, & Angert, 1993; Heide & Solomon, 1992; Tutty, Bidgood, & Rothery, 1993). Among sexually abused girls who received therapy, a decrease in psychological symptoms was evident following treatment (De-Luca, Hazen, & Cutler, 1993; Sauzier, 1989). Furthermore, in a 6-year follow-up of sexually abused women who received therapy, Bagley and Young (1998) found they had maintained therapeutic gains. Thus, utilization of psychotherapy would be a positive resource for victimization.

Social Network

Major reviews have shown that social support is important for physical and mental health (Cowen, Pedro-Carroll, & Alpert-Gillis, 1990; David & Suls, 1999; Dean & Lin, 1977; Lakey, Drew, & Sirl, 1999; Mitchell & Trickett, 1980; Pilisuk, 1982), reduction of stress (Dean & Lin, 1977; Mitchell & Trickett, 1980), and general coping (David & Suls, 1999; Dean & Lin, 1977; Lakey, Drew, & Sirl, 1999; Mitchell & Trickett, 1980; Pilisuk, 1982). A prerequisite for social support is a social network characterized by frequent interaction, close affective bonds, and exchanges of goods and services among family and non-family members who typically live together or near one another (Ellis, 1992; Lazarus, 1980; Jacobson, 1986). Members of social support networks interact by choice and are connected through social activities and mutual aid (Cantor, 1979), which can be either emotional or socioeconomic (Belle, 1987; Brown & Gary, 1985b; Ellis, 1992; Litwak, 1985; Soloman & Rothbaum, 1986). Early studies on personal adjustment and social behavior, as well as health maintenance and recovery from illness, demonstrated the significant positive influence of access to supportive

others and resulted in a variety of measures (Brown & Harris, 1978; Henderson, Duncan-Jones, & Byrne, 1981; Nuckolls, Cassel, & Kaplan, 1972; Sosa, Kennell, Klaus, Robertson, & Urrutia, 1980). Additional evidence mounted indicating that an appraisal of social support was more important than actual interpersonal contacts (Antonucci & Israel, 1986). Thus, the availability of a strong social network is an important coping resource. Indeed, the presence of a supportive social and familial network has been found to protect individuals from suicidal behavior (Kotler, Finkelstein, Molcho, Botsis, Plutchik, Brown, & van Praag, 1993; Nisbet, 1996) which is associated with social isolation (Josepho & Plutchik, 1994; Kotler et al., 1993).

The results of several studies suggested that parents who had sustained violence in their family of origin did not continue the cycle if they received social support during childhood or adulthood (Caliso & Milner, 1994; Crouch, Milner, & Caliso, 1995; Egeland, Sroufe, & Erickson, 1983; Hunter & Kilstrom, 1979; Milner, Robertson, & Rogers, 1990). Bowker (1983) and Ulrich (1998) found that social support was important for women leaving a violent partner. Women with the least social support appear to remain for longer periods of time in violent relationships and experience more severe violence and symptoms (Giles-Sims, 1998). Follingstad and colleagues (1990) and Dutton and Painter (1993) both argued that psychological abuse often results in social isolation through concerted domination and isolation tactics. Partner violence has been related to lower social support and greater psychological distress among low-income African American women (Thompson, Kaslow, Kingree, Rashid, Puett, Jacobs, & Mattews, 2000).

Childhood sexual victimization has been related to estrangement from family members and difficulty creating new support networks (Finkelhor & Browne, 1985; Gold, 1986; Herman, 1992). Social support moderated adult psychological adjustment following childhood sexual abuse (Testa, Miller, Downs, & Panek, 1992). Victims of childhood sexual abuse were more likely to be resilient if emotionally supportive others outside their family were available (Valentine & Feinauer, 1993). Several studies (Atkeson et al., 1982; Norris & Feldman-Summers, 1981; Ruch & Chandler, 1980; Sales, Baum, & Shore, 1984) have shown that rape victims reporting closeness to family members had relatively few psychological symptoms. Thus, the size of social networks appears to be an important resource which would allow women a variety of sources from which to obtain social support.

Sociocultural Factors

Several studies have shown that SES and ethnicity influence coping. However, few conclusions can be drawn regarding these relationships due to contradictory findings. Additionally, the speculative nature of theoretical work appears to be derived from ethnic or economic stereotypes or "common knowledge" rather than results of empirical research. For example, Hill, Hawkins, Raposo, & Carr, (1995) hypothesized that SES may moderate the relationship between victimization and coping but did not provide data to support this contention.

Socioeconomic Status. The relationship between the utilization of coping resources and SES remains unclear. Optimism has been found to be negatively related to SES (Metcalfe, 1998; Metcalfe & Shimamura, 1994; Scheier & Carver, 1985b). Perhaps

the high level of daily stressors coupled with a lack of financial resources give low-income women little opportunity to have these experiences that develop optimism. The daily struggles faced by low-income women appear to influence their use of some coping strategies due to their lack of financial resources to manage these stressors which hampers their ability to develop a sense of mastery over their environment (Metcalfe, 1998; Metcalfe & Shimamura, 1994; Scheier & Carver, 1985b) and may result in low self-esteem, decreasing the availability of this coping resource. Mitchell and Hodson (1983) found that minimal personal resources (i.e., income and education) contributed to lowered self-esteem in women who sustained partner violence. Dill, Feld, Martin, Beukema, and Belle's (1980) findings underscored the notion that what often appears to be the best strategy to cope with a given stressor may be quite complicated or impossible for women with limited resources and options. However, overcoming daily hassles and finding alternative means of coping despite limited finances may increase a woman's sense of self-esteem and optimism about her future. An increase in SES (i.e., education and employment) was also associated with women's increased use of intrapersonal coping resources such as introspection or private self-consciousness (Fernández-Esquer & McCloskey, 1999). Thus, SES may affect a woman's intrapersonal resources.

The literature on interpersonal coping resources is also unclear on the direction of influence associated with SES. Several studies (Bassuk & Browne, 1996; Belle, 1982b; Stack, 1974) report that low-income women survive through utilization of support networks to manage daily hassles. Early research suggested that these women tend to have social relationships of lesser quality (Belle, 1982b; Dohrenwend & Dohrenwend,

1970) but this finding was not supported by later studies (Ensel, 1986; Turner & Marino, 1994). Belle (1990) noted that although usually considered protective, social networks may be stressful and lead to psychological symptomology in low-income women because support relationship are reciprocal and members of the network experience similar stressors. Thus, social ties may provide low-income women with vicarious stress and burdensome dependence while limiting mobilization opportunities (Belle, 1982b). Low-income women may have relatively small networks. Bassuk et al., (1996) found that women in the Better Homes Fund study were isolated or had few relationships they could count on. Higher family income has been related larger support networks (Taylor, Hardison & Chatters, 1996). Ross and Mirowsky (1989) showed that income was unrelated to support, but level of education was positively associated. In general, studies show an association between higher income and education with larger networks and more contact with network members (Dohrenwend & Dohrenwend, 1970; Eckenrode, 1983; Fischer, 1982; Moody & Gray, 1972).

Ethnicity. Several studies have addressed the impact of ethnicity on women's coping resources. The increased importance of interpersonal relationships found among minority women as compared to Euro-American women (Roschelle, 1997) may influence the types of coping behaviors implemented. For example, Caldwell (1996) and Greenley, Mechanic, and Cleary, (1988) found that most African American women have extensive social networks with access to informal support. Thus, women of African and Mexican descent may be more likely to implement coping strategies that utilize their social support networks than Euro-American women. On the other hand, Mexican Americans reluctance

to involve outsiders in familial conflicts (Asbury, 1999) may make them less likely to seek support from nonkin or have nonkin individuals in their networks. Euro-Americans are more likely than African Americans or Mexican Americans to seek psychotherapy as a coping strategy, a trend that is more pronounced with low SES (Thompson & Smith, 1993). Thus, minority women may rely on friends and/or family for support while Euro-Americans may seek professional assistance in times of stress.

Ethnicity has been associated with intrapersonal coping resources. For example, poor self-concept may be associated with minority status (e.g., Rivers, 1995). Certain racial/ethnic traits are denigrated by American society (Olmeda & Parron, 1981) and some women may even deny their own ethnicity (Rivers, 1995), leading to alienation from others of the same ethnicity as well as the majority. Feelings of rejection due to cultural estrangement (Cozzarelli & Karafa, 1998) or other factors that may cause women to feel rejected or excluded are associated with low self-esteem (Branscombe, Schmitt, & Harvey, 1999) regardless of whether these feelings are due to culture, SES, or alienation following victimization. However, the research on ethnic differences in self-esteem is inconclusive, showing that self-esteem among African Americans is either lower (Porter & Washington, 1993) or higher (Crocker & Quinn, 1998; Gray-Little & Hafdahl, 2000) than that of Euro-Americans. Some studies indicate that Mexican American children have lower self-esteem than Euro-Americans or African Americans (Grossman, 1985; Knight, Kagan, Nelson, & Gumbiner, 1978; Stephen & Rosenfeld, 1978). Other studies find no difference between children in these ethnic groups (Samuels & Griffore, 1979; Larned & Muller, 1979; Franco 1983) and adults (Crocker & Major, 1989; Jensen, White &

Galliher, 1982). However, some of these contradictions may be caused by a confound between economic status and ethnicity. African Americans scored higher than Euro-Americans on self-esteem scales in both low and middle income groups with a larger difference between the low-income groups (Porter & Washington, 1979; 1989). Thus, African Americans with little income may feel more confident in their ability to survive and excel (i.e., cope) than their Euro-American counterparts.

Cultural values and ideals about women's roles may affect the ways they cope with victimization and the symptoms they exhibit. Gender-role attitudes vary by ethnicity (de Leon, 1993; Harris, 1996; Myers, 1989; Reid & Bing, 2000; Roschelle, 1997) and may be associated with the type of coping strategies women utilize. African Americans and Euro-Americans seek more egalitarian relationships than Mexican Americans (de Leon, 1993; Harris, 1996; Miller, 1978). African American women perceive their role as more androgynous in relationships (Harris, 1996), while Mexican Americans may maintain a patriarchal family structure (Miller, 1978; Peñalosa, 1968). Mexican Americans traditionally come from close-knit family units and are very dependent on one another for economic and social support, factors that seem to diminish the tendency for violence. Thus, the focus on equality between the sexes in African American and Euro-American women and the submissive stance taken by Mexican American women may impact the way they cope with victimization, especially by their partners.

Some similarities and differences have emerged for coping with victimization. Fernández-Esquer and McCloskey (1999) found that ethnicity (Mexican American and Euro-American) was not associated with women's strategies for coping with partner

physical, sexual, and verbal abuse. Torres (1991) found that Hispanic and Euro-American women differed in their perceptions of abuse in that hitting and verbal aggression had to occur more frequently for Hispanic women to consider it abuse, which likely influences their use of coping strategies. Cazenave and Straus (1979) found less spousal slapping in African American couples who were embedded in social networks, but no effect was found among Euro-Americans. Only among African Americans was the number of years in the neighborhood associated with less severe partner violence. African American victims of partner violence were less likely to engage in suicidal behavior if they had access to social support (Kaslow et al., 1998). Sanders-Phillips, Moisan, Wadlington, Morgan, and English (1995) reported that Mexican Americans girls who sustained sexual assault tended to receive less maternal support than African American counterparts. No studies that addressed ethnic differences for coping with adult sexual assault or psychological abuse were found.

In sum, these considerations suggest the resources and strategies women develop to cope with victimization may stem from the specific demands of the situation (Hill, Hawkins, Raposo, & Carr, 1995; Lazarus, 1980, 1993; Lazarus & Folkman, 1984), as well as their cultural background, and/or economic resources (Gelles, 1980; McCloskey, 1996; O'Brien, 1974; Perilla, Bakeman, & Norris, 1994). Research has shown that women utilize a variety of strategies to cope with victimization perpetrated by their partners (Blackman, 1989; Fernández-Esquer & McCloskey, 1999; Frieze & McHugh, 1992; Mills, 1985), yet there have been few attempts to assess the utilization of these strategies within a sociocultural or socioeconomic framework, probably due to a tendency

to assume that patterns are universal and not bound by culture (Fernández-Esquer & McCloskey, 1999; Hill et al., 1995). The literature does not address whether reactions to victimization are partly due to a person's culture, stress inherent in socioeconomic conditions, or an interaction of both. By holding SES constant, this study addressed ethnicity without the common confound with income.

This review of the literature suggests that openness, the ability to form, maintain, and benefit from interpersonal relationships, may underlie coping resources. Openness allows the use of effective strategies for coping with stressful daily events (David & Suls, 1999) as indicated by self-reports and independent assessments during organizational change (Judge, Thoresen, Pucik, & Welbourne, 1999). Obviously, openness to relationships is important for interpersonal resources and strategies. Repeatedly, the efficacy of psychotherapy and social support for individuals suffering health-related problems has been shown (e.g., Parry, 1990), however, an open and honest relationship is necessary for therapy (e.g., Anderson, Ogles, & Weis, 1999; Brown, 1990; Keijsers, Schapp, & Hoogduin, 2000; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998) and relationships with others to be effective. Greater openness with others and emotional expression are positively related to use of active coping strategies and general improvement in coping skills (Classen, Diamond, & Spiegel, 1999).

Openness is also important for intrapersonal coping resources. Communication allows individuals to gain information and view situations from different perspectives, which is likely to result in enhanced problem solving. By increasing the available information, the introspection of individuals high in private self-consciousness may be

more effective. Openness to relationships may also be related to optimism, because optimists seek more social support than individuals low in optimism (Scheier, Weintraub, & Carver, 1985) and may be more able to utilize these resources through obtaining encouragement and positive feedback from others. Openness in relationships is associated with higher self-esteem (Dolgin, Meyer, & Schwartz, 1991; Papini, Farmer, Clark, & Micka, 1990; Vera & Betz, 1992). Perhaps through open disclosure of thoughts, feelings and behavior, positive feedback from others increases a sense of self-worth.

Some studies have demonstrated the efficacy openness to relationships has on coping with victimization. Burt and Katz (1987) found that expressive coping behaviors were the only coping strategy not associated with guilt or self-blame following rape. Frazier and Burnett (1994) found that among rape victims, emotion-focused coping strategies, such as the open expression of feelings, were more helpful than problem solving strategies in decreasing psychological symptoms. Furthermore, support seeking strategies, such as the utilization of social support or psychotherapy, were also more effective than avoidance focused strategies in decreasing psychological symptoms (Frazier & Burnett, 1994). Overall, a lack of openness decreases a woman's available coping strategies for dealing with victimization. Thus, openness appears to be important to the utilization of coping resources, in general, and to deal with victimization specifically.

Openness

Herein, openness refers to a tendency to be receptive to relationships with others. In the literature, openness has been described as a communication style (e.g., Brown-

Smith, 1998; Brown & Rogers, 1991; Eisneberg & Witten, 1987; Feder, 1974; Honeycutt, 1986; McClelland, 1987) involving being receptive and/or responsive to novelty through mindfulness (e.g., Langer, 1992), openness to feelings and intimacy (e.g., Berlin, 1987; Cartwright & Mori, 1988; Friedman, 1977; Masserman & Uribe, 1989), to the unconscious during therapy (Purton, 1989; Shapiro, 1983) and to change (e.g., Greenberger, Campbell, Sorensen, O'Connor, 1971; James, Hater, Gent, & Bruni, 1978) as well as one of the Big Five personality dimensions (e.g., Costa, McCrae, & Dye, 1991; John, 1990; Mervielde, De Fruyt, Jarmuz, 1998; Radford, 1976; Tennen & Affleck, 1998). Studies from these perspectives have shown positive associations with interpersonal relationships (Berlin, 1987; Brown & Rogers, 1991; Honeycutt, 1986; Masserman & Uribe, 1989), intelligence (Langer, 1992; Mervielde, De Fruyt, Jarmuz, 1998; Schutte, Malouff, Hall, Haggerty, Cooper, Golden, & Dornheim, 1998), personal and family functioning (Berlin, 1987; Brown-Smith, 1998; David & Suls, 1999; Farberow, 1989; Medvedova, 1998; Radford, 1976; Stevens, 1992), psychotherapeutic change (Berlin, 1987; Classen, Diamond, & Spiegel, 1999; Frank, 1974; Friedman, 1987; Greenberger, et al., 1971; James, et al., 1978; Mahrer & Gervaize, 1984; Purton, 1989; Radford, 1976; Shapiro, 1983), locus of control (David & Suls, 1999; Stevens, 1992), leadership abilities (Smith, Smith, & Barnette, 1991), job performance (McClelland, 1987; Mount & Barrick, 1991, 1998), and coping with organizational change (Judge, Thoresen, Pucik, & Welbourne, 1999). These approaches have a common core. To be open is to have the ability to form, maintain, and benefit from interpersonal relationships

in which self-disclosure occurs. Openness likely affects the efficacy of coping and is likely affected by victimization.

Openness may mediate the relationship between victimization and coping. Disclosure of victimization, especially violence, has been found to help increase self-esteem (Dieckermann, 2000). Responses following disclosure of childhood victimization have also been linked to higher self-esteem through adulthood (Palmer, Brown, Rae, Naomi, & Loughlin, 1999). Women who received supportive reactions following disclosure of childhood sexual abuse had fewer psychological symptoms and higher self-esteem than those who did not receive support (Testa et al., 1992). Concealment of stress related issues, such as sexual assault (Perrott, Morris, Martin, & Romans, 1998), has been linked to lower self-esteem (Ichiyama, Colbert, Laramore, & Heim, 1993). These findings show the importance of disclosure in coping with victimization.

Several indicators of openness were used in this study. A positive orientation to social networks indicates that openness is necessary to the formation, maintenance, and effectiveness of relationships. Communal orientation is an aspect of openness that allows awareness and acceptance that relationships involve sensitivity to each other's needs. Interpersonal trust is necessary to allow for personal disclosures to occur through the belief in the benevolence of others. Refraining from self-monitoring encourages open expression of thoughts, feelings and values as opposed to responding to the environmental cues. Openness, the opposite of self-silencing in relationships, would also allow discussion of problems and feelings. These five indicators constituted openness in this study.

Network Orientation

Network orientation is a set of beliefs, attitudes, and expectations concerning the potential usefulness of a social network in helping individuals cope with problems (Tolsdorf, 1976). Individuals low in network orientation may not lack support resources, rather they tend to be unwilling to maintain, nurture, and utilize other individuals (Vaux, Burda, & Stewart, 1986). They believe it is inadvisable, impossible, useless, or potentially dangerous to utilize their social resources (Tolsdorf, 1976). In contrast, a positive network orientation involves a willingness to take interpersonal risks through seeking social support from available people (Vaux, Burda, & Stewart, 1986). Individuals with a secure attachment style had a stronger network orientation than their avoidant or anxious-ambivalent peers (Pretorious, 1993; Wallace & Vaux, 1993). Thus, individuals high in network orientation are open to and engage in interpersonal relationships, despite the potential risks.

Having a positive network orientation provides a variety of options for coping with stressors. Network orientation has been found to predict the use of a social support network when experiencing psychological distress (Barrera & Baca, 1990). For example, individuals in need of economic assistance or emotional support who are high in network orientation would be likely to seek others who may assist them. A negative network orientation limits the potential for coping by decreasing willingness to request assistance from others. It is associated with low levels of interpersonal trust and self-disclosure (Vaux, Burda, & Stewart, 1986). In addition, network orientation is related to therapy. Tata and Leong (1994) found positive network orientation was a significant predictor of

attitudes towards seeking psychotherapy. Belle, Dill, and Burr (1991) found that positive network orientation was associated with higher self-esteem and a more internal locus of control, as is often found among those high in private self-consciousness. Thus, a high network orientation has been found to be associated with several coping resources.

Network orientation has been associated with mental health. For example, high network orientation as demonstrated by greater utilization of social support, was associated with reduced psychological distress in general (Brown & Gary, 1985a; Horowitz & Bordens, 1995; Thomas, Milburn, Brown, & Gary, 1988) and after an abortion (Major, Richards, Cooper, Cozzarelli, & Zubek, 1998). Reif, Patton, and Gold (1995) found that low network orientation was associated with more severe stress responses following the death of a child. Pretorius (1994) found network orientation independently, and in interaction with social support, moderated the effects of stress on depression. East (1989) found that negative network orientation was associated with loneliness, low self-esteem, and depression.

Victimization, especially if chronic, may decrease women's network orientation. Single incidents of interpersonal aggression (e.g., rape, dating violence), if accompanied by positive reactions from others to whom a woman discloses the assault, are not likely to severely damage network orientation. However, negative reactions to disclosure following either repeated or discrete assaults may cause a woman to question the usefulness of social support. Some research supports these contentions. Ruback, Greenberg, and Westcott (1984) found that after victimization, survivors decide what to do based on knowledge of various options and estimation of who would be likely and

able to offer help and most likely to take their disclosures seriously. Freize, Knoble, Washburn, and Zomnir (1980) found that 55% of battered women sought help from a variety of sources including relatives, friends, and ministers and priests, demonstrating a positive network orientation. However, the benefits of disclosure also are weighed against norms that may include loyalty to family members, protecting the privacy of the family, and not trusting those from other ethnic or social groups (Browne, 1991). Women who sustained sexual abuse for longer periods of time with more incidents had lower network orientations than those reporting fewer incidents and a control group (Gibson & Hartshorne, 1996). Thus, the duration of victimization may influence network orientation. However, women with positive network orientations have been found to utilize their social networks as means of coping with their victimization. Thus, openness to relationships, as measured by a positive network orientation, appears to improve a woman's ability to cope with victimization.

Interpersonal Trust

Another indicator of openness with clear implications for coping with victimization is interpersonal trust. Trust is the belief that the sincerity, benevolence, or truthfulness of others generally can be relied upon (e.g., Rotter, 1967; Wrightsman, 1974). It allows individuals to feel comfortable in relationships and express themselves to others. Steel (1991) defined trust as the expectancy for positive outcomes following self-disclosure and openness as being receptive to intimacy and feelings in relationships. She found a positive correlation between these variables. To Steel (1991), trust allows an individual to discuss information with others that may be personal, controversial, or

emotionally laden. This trusting openness appears to be a key element to decreasing global distress through obtaining support and utilizating interpersonal coping resources (Brown, Stout, & Gannon-Rowley, 1998; Drews & Bradley, 1989; Evans, 1978; Folkman, Lazarus, Gruen, & DeLongis, 1986; Kaufman & Wohl, 1992; Kelley, Coursey, & Selby, 1997; Kim-Goh, Suh, Blake, Hiley, 1995; Lubell & Soong, 1982; Newman, Orsillo, Herman, & Niles, 1995; Pennebaker, 1997; Sadavoy, 1997). With adverse life events, individuals high in trust engage in more disclosure (Bierhoff, 1992; Drews & Bradley, 1989; Lubell & Soong, 1982; Pennebaker, 1997; Sadavoy, 1997; Tyler, 1979), social support (Bierhoff, 1992; Evans, 1978; Folkman et al., 1986; Heiberg, Sorensen, & Olafsen, 1975; Kaufman & Wohl, 1992; Kelley et al., 1997; Lubell & Soong, 1982; Pennebaker, 1997; Tyler, 1979), cooperation with others (Bierhoff, 1992; Kelley et al., 1997; Lubell & Soong, 1982), and are willing to seek out and accept the advice of professionals (Bierhoff, 1992; Brown et al., 1998; Drews & Bradley, 1989; Evans, 1978; Heiberg, Sorensen, & Olafsen, 1975; Kaufman & Wohl, 1992; Kelley et al., 1997; Lubell & Soong, 1982; Pennebaker, 1997; Tyler, 1979) than those low in trust. Interpersonal trust, therefore, may be a key factor in decreasing global distress by encouraging self-disclosure and use of interpersonal coping resources.

Victimization is likely to impact trust. Sustained physical (Brack, Brack, & Infante, 1995; Burge, 1989; Finkelhor & Browne, 1985; Matsakis, 1998; Solomon & Heide, 1999), psychological (Brack, Brack, & Infante, 1995), and sexual assaults (Bourdon & Cook, 1993; Brack, Brack, & Infante, 1995; Chew, 1998; Cole & Putnam, 1992; Courtois, 2000; Dahl, 1993; DiLillo & Long, 1999; Drews & Bradley, 1989;

Evans, 1978; Hartman & Burgess, 1993; Hill & Alexander, 1993; Jehu, 1992; Kaufman & Wohl, 1992; Lubell & Soong, 1982; Pynoos, Nader, Black, Kaplan, Hendricks, Gordon, Wraith, Green, Herman, 1993; Resnick & Schnicke, 1993; Saunders & Edelson, 1999; Solomon and Heide, 1999; Wenninger & Ehlers, 1998; Westwell, 1998; Witchel, 1991) result in a mistrust of others. Aggression, perhaps especially when inflicted by a parent or partner, encourages the belief that others will cause harm, thereby decreasing trust. The impact of chronic victimization (i.e., child abuse, partner violence) likely decreases trust as much, if not more, than a single incident. Chronic and revictimizations are likely to decrease a woman's belief in the benevolence and trustworthiness of others. It may be, however, that the mistrust following victimization as an adult is directed toward the male aggressor or men in general. If women receive supportive reactions from others following disclosure of victimization, their positive beliefs in others could be reinforced and their sense of trust strengthened (Chwalisz & Garwood, 1991). Unfortunately, women have been found to re-experience feelings of dependence, powerlessness, humiliation, a betrayal of trust, and unsupportive responses when they disclose victimization (Hamilton, Alagna, King, & Lloyd, 1987). According to Russell (1986), women's ability to judge the trustworthiness of others may be impaired by childhood incest and could lead to revictimization. Logic suggests this generalized distrust could also occur with physical abuse by parents. Thus, trust in others is necessary for interpersonal openness and may be diminished by victimization.

Communal Orientation

A third indicator of openness is communal orientation, the belief that people should be sensitive and receptive to the needs of others (Clark & Mills, 1979). In communal relationships, individuals feel responsible for the other's welfare and assume the other feels responsible for them (Clark, Ouellette, Powell, & Milberg, 1987). Individuals with this orientation desire and/or feel obligated to provide assistance when others have a need and assume reciprocity for their own needs. Thompson and De Harpport (1998) found that individuals high in communal orientation are more likely to allocate resources equally among each other than are those low in this orientation. Women, more than men, value communal relationships and believe in their ability to gain from and provide assistance to others (Jones, 1991; Stein, Newcomb, & Bentler, 1992; Yee, Greenberg, & Beach, 1998); whereas men value more agentic, individually oriented relationships. This acceptance of the benefits and costs of interpersonal relationships allows women to seek and obtain support during times of stress. Communal orientation is associated with trust in partners (Zak, Gold, Ryckman, & Lenney, 1998), friends (Jones, 1991), the ability to develop and maintain close friendships with a positive conception of friends (Jones, Bloys, & Wood, 1990), and satisfaction with friendships (Jones & Vaughn, 1990). Thus, communal orientation appears important to considerations of openness.

Behavior associated with communal orientation may also increase the availability of intrapersonal coping resources. Monnier, Hobfoll, and Stone's (1996) Multi-Axial Model of Coping is behaviorally consistent with a communal orientation. Healthy coping

is both active and pro-social, requiring openness to interpersonal relationships. In support, McCall (1995) found that individuals high in communal orientation were more likely to credit their partners after successful decision-making tasks than to blame them following failure. Individuals high in communal orientation did not change their attributions for their own performance, but were able to provide pro-social feedback to their partners. This encouragement may increase the likelihood of obtaining assistance and support from others when needed in the future. Thus, behavior consistent with a communal orientation is likely to result in more efficacious coping opportunities.

Low communal orientation is associated with interpersonal distance. Medvene, Volk, and Meissen (1997) found that communal orientation was negatively related to depersonalization among self-help group leaders and thus positively related to interpersonal openness. Individuals with negative attitudes toward their own and others willingness to help disengaged from a coping resource. Furthermore, VanYperen (1996) and VanYperen, Buunk, and Schaufeli (1992) found that nurses low in communal orientation who perceived an inequity in relationships with patients attempted to restore equity through emotional distancing. The tendency to distance from others would decrease openness making interpersonal coping options less likely.

High communal orientation is related to coping resources such as self-esteem and the use of social support (Stein, Newcomb, & Bentler, 1992; Watson, Biderman, & Sawrie, 1994; Watson & Morris, 1994). Thompson, Medvene, & Freedman (1995) found individuals low in communal orientation felt underbenefitted and resented their spouse when providing health care assistance. Those with high communal orientations coped

more effectively and were less depressed than individuals low in communal orientation during a stressful situation requiring them to provide care for others (Williamson & Schulz, 1990). Watson, Morris, Hood, & Folbrecht (1990) found that low communal orientation and high individualism decreased social support networks thereby decreasing the ability to cope with stress. Thus, communal orientation as one form of openness appears to have a positive impact on coping.

No research has specifically addressed the impact of victimization on communal orientation. However, it is likely that violence by parents and/or partners and psychological abuse, as well as sexual assault by an acquaintance or loved one would decrease communal orientation. Whether victimization was a discrete event of aggression or chronic assaults, women may learn to expect harm in close relationships rather than sensitivity to and acceptance of their needs. This, in turn, could decrease the likelihood they would seek or accept help from others to cope with problems. On the other hand, Harvey, Orbuch, Chwalisz, & Garwood (1991) found that empathic confidant reactions expected in communal relationships, was related to successful coping with sexual assault. Although victimizing acts may decrease communal orientation, the reactions of those to whom women disclose may enhance communal orientation. Thus, victimization likely decreases communal orientation if not met with empathic reactions, thereby limiting available coping resources, especially social networks.

Self-Monitoring

A negative indicator of openness to relationships, self-monitoring, may also be important to coping. All individuals attend to social cues but low and high self-monitors

use the information differently (Snyder, 1979). Low self-monitors use cues to determine how to express their internal attitudes, beliefs and emotions, valuing consistency between their inner self and the person they present to others. In contrast, high self-monitors are skilled interpersonal managers (Furnham & Capon, 1983; Snyder, 1987) who pay little attention to their own attitudes, beliefs, and feelings when making behavioral decisions showing relatively little cross-situational consistency (Lennox & Wolfe, 1984; Snyder, Campbell, & Preston, 1982; Snyder & Monson, 1975). They are more attentive to social cues in ambiguous situations, learn appropriate social behaviors more rapidly, and are better at understanding nonverbal behaviors than low self-monitors (Brigham, 1991). They prefer partitioned, compartmentalized social worlds in which they engage in particular activities only with specific partners (Snyder, Gangestad, & Simpson, 1983). One dimension of self-monitoring is concern for appropriateness (Wolfe, Lennox, & Cutler, 1986). Individuals high in concern for appropriateness possess little social anxiety and shyness (Tomarelli & Shaffer, 1985). This component of self-monitoring has been found to be positively associated with sociability, cross situational behavioral variability, and attention to social comparison information (Lennox & Wolfe, 1984; Wolfe et al., 1986).

Self-monitoring has been positively associated with social competence (Hamilton & Baumeister, 1984; Schoenrock, Bell, Sun, & Avery, 1999), social desirability (Stewart & Carley, 1984), appearing relaxed and friendly in social situations, extraversion (Lenox, 1984; Montag & Levin, 1990), an increased tendency to initiate social interactions (Brigham, 1991) and negatively associated with contentment with oneself without

concern for the opinion others (Snyder, 1987). Characteristics associated with high self-monitoring initially may appear to reflect interpersonal openness, but they actually represent manifestations of social skill. On the surface, it would appear that concern for appropriateness would be a positive indicator of openness because it would facilitate pleasant and agreeable interpersonal relationships. However, the lack of desire to share their inner self with others, lack of cross situational consistency, and compartmentalizing suggests the relationships of high self-monitors would be superficial, especially among those his in the concern for appropriateness component. Consequently, low self-monitoring is a positive indicator or openness (i.e., concern for appropriateness is negatively related to openness).

Several characteristics associated with high self-monitoring have implications for coping. Friedman and Miller-Herrenger (1991) found they were more successful at hiding emotions from others than low self-monitors. When emotions are hidden, offers of social support may not be forthcoming. High self-monitoring has also been associated with placing greater weight on external physical appearance than internal personal attributes, thoughts, feelings and values (Snyder, Berscheid, & Glick, 1985). This suggests members of a social network would not be chosen for their internal characteristics. The willingness to terminate current relationships in favor of alternative partners (Snyder & Simpson, 1984) could lead to frequent changes in members of a social network. More directly, high self-monitors have been found to be deficient in coping resources such as self-esteem (Briggs, & Cheek, 1988; Lennox, 1984; Wolfe, Lennox, & Cutler, 1986), optimism (Polak & Prokop, 1989), private self-consciousness (Tomarelli & Shaffer, 1985) and

access to their inner experience of emotions, thoughts and values (Anderson & Tolson, 1989; Haverkamp, 1994). Their ability to effectively utilize psychotherapy is limited by their tendency to attend to social norms as opposed to their own attitudes, beliefs and feelings (Furnham & Capon, 1983; Snyder, 1987) and ability to hide emotions (Friedman & Miller-Herrenger, 1991). Thus, factors associated with self-monitoring likely decrease the ability to effectively utilize several coping resources.

Victimization may be linked to an increase in self-monitoring behavior, especially concern for appropriateness. Gaensbauer and Sands (1979) found that abused and neglected children were less facially expressive and more verbally inhibited than nonabused peers suggesting development of a high self-monitoring style in relationships. Similarly, partner violence and psychological abuse may encourage high self-monitoring as women attempt to deflect or avoid further victimization. Abused women may come to believe that showing their feelings, beliefs, and attitudes could result in being harmed. Because it may be difficult for many women to behave in a high self-monitoring manner with their partners and as a low self-monitor with others, women victimized by their partner may increasingly develop a high self-monitoring style during all social interactions. A concern with behaving in a socially appropriate manner, regardless of the situation, may become more important than letting others know them as they are. It is less likely that sexual assault would affect self-monitoring unless it was done by a close other during childhood, especially if the woman thinks it would not have happened had she behaved appropriately.

Silencing the Self

Self-silencing, is a way to maintain interpersonal relationships by suppressing thoughts, feelings, values, and needs (Jack, 1991). Jack (1991) argued and others (Brody, Haaga, Kirk, & Solomon, 1999; Carr, Gilroy, & Sherman, 1996; Dill & Anderson, 1999; Dunlap, 1997; Gratch, Bassett, & Attra, 1995; Hart, & Thompson, 1996; Jack, 1999a; Jack & Dill, 1992; Page, Stevens, & Galvin, 1996; Thompson, 1995) found that depressed women have cognitive schemas about creating and maintaining relationships by refraining from open disclosure of their feelings and needs to avoid conflict and the potential loss of relationships. Self-silencing results in a lack of self-disclosure and openness to interpersonal relationships (Carr, Gilroy, & Sherman, 1996; Dill & Anderson, 1999; Dunlap, 1997; Gratch, Bassett, & Attra, 1995; Hart, & Thompson, 1996; Jack, 1999b; Jack & Dill, 1992; Page, Stevens, & Galvin, 1996; Thompson, 1995), as well the specific suppression of anger (Brody, Haaga, Kirk, & Solomon, 1999). Thus, self-silencing would be a negative indicator of openness.

Self-silencing likely decreases coping resources. Women with fewer self-silencing beliefs have exhibited more efficacious coping involving use of social networks following diagnosis with cancer (Kayser, Sormanti, & Strainchamps, 1999). DeMarco, Miller, Patsdaughter, Chisholm, and Grindel (1998) found that decreased self-silencing was associated with better interpersonal and action oriented coping following HIV/AIDS diagnosis. Women who silence thoughts, feelings, values, and needs are unlikely to utilize coping resources such as psychotherapy and a social support network. Self-

silencing also has been negatively associated with self-esteem (Page, Stevens, & Galvin, 1996; Woods, 1999).

Victimization may lead to self-silencing. Victims of family of origin violence have been found to be less expressiveness than individuals from nonviolent families (Milner & Chilamkurti, 1991). Jack and Dill (1992) and Woods (1999) found that women who sustained partner violence and/or psychological abuse were higher in self-silencing and disconnection with their partner than nonabused women. Ali and colleagues (2000) found that self-silencing mediated the relationship between psychological abuse and gastrointestinal functioning. Although, the self-blame often experienced by victims of sexual assault (e.g., Burt & Katz, 1987) may increase women's tendency to self-silence, adult sexual victimizations by nonpartners is less likely to have an effect than partner physical, sexual, and psychological abuse

In sum, by trusting others, refraining from silencing one's thoughts and feelings or monitoring communication, and having a positive view of social support in general and its reciprocal nature, a positive effect on coping is likely via an openness to interpersonal relationships. The efficacy of external coping skills, such as seeking social support and psychotherapy, largely depend on open communication and disclosure. Yet openness is likely to be adversely affected by victimization. These considerations suggest coping with victimization is likely to be mediated by openness. However, there may be socioeconomic and ethnic variables that influence openness.

Sociocultural Variables

`Little research could be found that related to SES and openness. Some studies and theorists have addressed the association between ethnicity and interpersonal openness. Findings appear consistent regarding the propensity towards open communication in the African American and Euro-American communities and communication aimed at maintaining smooth relationships in the Mexican American community.

Socioeconomic Status. Little research addresses how poverty may be associated with interpersonal openness. Herrenhokl, Herrenhokl, Toedter, & Yanushefski (1984) found higher family income was related to better communication skills, but this does not necessarily imply differences in self-disclosure or the ability to form and maintain relationships. The only study addressing the impact of financial status on openness found that homeless women had a more negative network orientation (i.e., less openness) than low-income housed women despite similar levels of interpersonal trust (Goodman, 1991b). With the dearth of research in this area, no predictions can be made regarding the impact of SES on openness to relationships.

Ethnicity. The importance of openness in and reliance on relationships can be seen in the values often associated with ethnic minorities. For example, African American cultural values appear to include harmony and communalism rather than individualism (APA, 1993), which indicate the importance placed on relationships. They value other's interest in getting to know them (Kochman, 1981). Kochman (1981) noted that African Americans value openness and the ability to express rather than repress (self-

silence) thoughts and emotions. Consequently, some African Americans' communication style is intense, outspoken, challenging, forward and assertive (Hecht, Collier, & Ribeau, 1993). African Americans may more openly express emotions such as anger in close relationships (Kochman, 1981; Ting-Toomey, 1986).

Similarly, Mexican Americans' identify with and are attached to the nuclear and extended family, exhibiting loyalty, reciprocity, and solidarity with their family members (APA, 1993). They behave to promote smooth and pleasant relationships often by silencing their feelings and thoughts (Marin & Marin, 1991), suggesting concern for appropriateness (i.e., less openness). Although African Americans and Mexican Americans appear to have specific values regarding the openness in interpersonal relationships, African Americans may be more open. Openness may be more important for effective coping with victimization among African Americans than Mexican Americans. Given the dearth of research on ethnic differences in factors associated with openness, further discussion would be speculative in nature.

In contrast, there are several studies on ethnicity, victimization, and openness. Mexican Americans have been found to refrain from acknowledging and disclosing violence in the family to others (APA, 1993; Marin & Marin, 1991). Given the more open expression of conflict found in African-American and Euro-American cultures, they may be more likely to disclose partner and family of origin violence than Mexican American women. The lower rates of rejection by African American mothers after disclosure of sexual assault compared to Euro-American mothers found by Pierce and Pierce (1984) suggests African Americans may be more likely to disclose some types of victimization

than Euro-Americans. In contrast, Abney and Priest (1995) found denial regarding the presence of sexual abuse of children in African American communities. These findings may not necessarily conflict with each other. African Americans may be more accepting of disclosing victimization in their interpersonal relationships (i.e., more open with each other), yet believe that silence outside these relationships could protect an African American perpetrator, who would likely receive more severe legal penalties than a White male (Abney & Priest, 1995).

Research supports a lack of openness among Mexican Americans regarding victimization as well. Levy (1988) reported a number of patterns specific to child sexual abuse in the Hispanic community that may hinder women's tendency to disclose victimization. The general expectation that women must suffer in silence suggests that partner violence and psychological abuse would not be openly disclosed to others. Attitudes that sexual behavior is too intimate to discuss and the expectation women will marry as virgins suggests that sexual assault would not be disclosed. Thus, Mexican American women are likely to refrain from discussing victimization.

CHAPTER II

MODEL AND RATIONALE FOR THE STUDY

The review of the literature resulted in the model shown in Figure 1. Although the effect of Victimization on Psychological Symptoms has been clearly established in research for child abuse, partner violence, sexual assault and some studies on psychological abuse, the model proposes this relationship is mediated by coping. As discussed, Openness may be necessary for effective Coping. To obtain help and assistance in times of stress, it is necessary to have close, effective interpersonal relationships with the freedom to disclose sensitive personal information. Through Openness to relationships, more effective Coping resources can be developed and strategies implemented. However, Openness is likely to be adversely affected by Victimization. Thus, the model tested in this study proposed that the relationship between Victimization and Coping would be partially mediated by the effects of Victimization on Openness.

There are several reasons why low-income ethnically diverse women represented a useful sample with which to test this model. First, ethnic differences and similarities could be examined without the confound between ethnicity and SES. Second, there was no consensus on the prevalence and effects of victimization among low-income or ethnically diverse populations. Third, these women may be at higher risk for psychological symptoms, even without Victimization, due to the everyday stressors low-income women experience. On the other hand, women of low SES and from ethnic

minorities may be able to withstand some effects of violence because of previously developed Coping resources due to the stress in their everyday lives. Fourth, women from this population may sustain more negative consequences of Psychological Symptoms (e.g., inability to work) than women from less disadvantaged populations. Finally, learning more about how low-income and ethnically diverse women are affected by violence is important for the counseling literature on cultural and economic diversity. SES was controlled by limiting the sample to low income women, living within 200% of the poverty threshold. Although not shown in the figure, ethnicity was added as a moderator variable. The results of Structural Equation Modeling were expected to vary by ethnicity.

Use of a community sample also addressed limitations found in the literature. In much of the research on victimization, clinical samples, chosen specifically for the presence of an assault, have been used. The ease of accessing victims of sexual assault and partner violence through hospital emergency rooms, the police (e.g., Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; Briere, Woo, McRae, Foltz, & Sitzman, 1997; Burgess & Holmstrom, 1974), and battered women's shelters (e.g., Downs, Miller, Testa, & Panek, 1993; Koslof, 1984; Mitchell & Hodson, 1986; Pagelow, 1981; Snyder & Fruchtman, 1981; Walker, 1979) contributed to the tendency to study clinical populations. However, there are several limitations identified with these samples. For example, the police are rarely called to middle and upper class homes despite data showing that no form of violence occurs exclusively among low-income families (McKendy, 1997; Sherman, Schmidt, & Rogan, 1992). Furthermore, very few women go

to shelters even when badly beaten (Bograd, 1988; VanHorn & Marshall, 2000), and women rarely implicate their partner or an acquaintance to emergency room personnel unless specifically asked (Kurz & Stark, 1989), and they are rarely asked (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; Briere, Woo, McRae, Foltz, & Sitzman, 1997; Burgess & Holmstrom, 1974). Clinical samples of women in therapy are also limited and likely to differ from the general population due to the small percentage of individuals who seek therapy. Thus, logic dictates and studies have shown that only a small proportion of sexual assault and physical violence victims ever become identified as such (Bergen, 1998; Hilberman, 1977; Rounsaville & Weissman, 1977). Given that rape and domestic violence may be the most under-reported crimes committed (Bachman, 1998; Hilberman, 1977; Koss, 1997; Rounsaville & Weissman, 1977), samples identified for the presence of victimization are problematic because they exclude a wide segment of victims. On the other hand, the national victimization surveys have been found to be limited by inadequate screening questions and insufficient detail (Bachman, 1995; Chilton & Jarvis, 1999; Conaway & Lohr, 1994; Hashima & Finkelhor, 1999; Koss, 1994; Percy & Mayhew, 1997; Pollard, 1995). Use of a community sample of urban women allowed this study to overcome these problems.

CHAPTER III

METHOD

Participants

Eight hundred and thirty six women from the southwest area of Dallas County, Texas participated in a longitudinal study called Project HOW: Health Outcomes of Women. Data for this study were from the first three waves of interviews. To participate, women had to be between the ages of 20 and 49 (M = 33.3 years), have an earned household income within 200% of poverty (M = 92%) and/or receive public aid at the time of their first interview, and be involved a self-defined serious relationship with a man for at least one year (M = 7.7 years). Women were dating (n = 201, 24%), cohabiting (n = 107, 12.8%), or married (n = 528, 63.2%) to their partner. The initial sample consisted of 303 (36.2%) African American, 273 (32.7%) Euro-American, and 260 (31.1%) Mexican American women. At Wave 1, slightly over one-third reported their education as a high school diploma or General Equivalency Degree (n = 321, 38.4%). Less than one-third of the participants had not completed high school (n = 238, 28.5%). Some women had some college or completed an Associate's degree (n = 100, 12%), a Bachelor's degree (n = 31, 3.7%), or a Master's degree (n = 4, 0.5%).

Chi-Square ($?^2$) and Analyses of Variance (AVONA) procedures were used to assess attrition. Several differences emerged. Proportionately more African Americans (n = 245, 38.8%) and Mexican Americans (n = 202, 32.0%) than Euro-Americans (n = 185, 29.3%) participated in all three waves, $?^2$(N = 835, df=2)=14.74, p < .001. Thus, only

19.1% of African Americans and 22.3% of Mexican Americans did not complete all waves compared to 32.2% of Euro-Americans. Additionally, women who participated in all waves tended to be older (M = 32.80 year) than women who did not (M = 29.98), F(1,833)=15.11, p < .000. More women initially in dating (n = 153, 24.2%) and married relationships (n = 409, 64.7%) completed the three waves than cohabiting women (n = 70, 11.1%), $?^2$(N = 835, df=2)=7.21, p < .03. Women in longer relationships (M = 8.14 years) were also more likely to complete all three waves than women in shorter (M = 6.37 years) relationships F(1,832)=11.26, p < .001. Education did not differ for women who complete these waves, F(1,833)=1.26, p < .263.

Procedure

Recruitment. Women were recruited to participate in a four wave longitudinal study of factors that impact their health. Recruitment began in May 1995 and was completed in December 1996. The variety of methods included a snowball technique with participants referring other women, personal contact (at health fairs, community centers, stores, parking lots, and similar sites), and English and Spanish flyers distributed through churches, schools (pre-schools to junior colleges), community events (e.g., Health Fairs, Job Fairs, women's gatherings), social service and health care agencies, and left in public places (e.g., libraries, convenience stores, other businesses). A mass mailing of over 18,000 letters were sent to women in targeted areas using a mailing list purchased from an independent company. The mailing consisted of a letter (Appendix A) and two to three flyers inviting women to call the project offices. Additionally, public service announcements were made, in both English and Spanish, on local radio stations and

minority newspapers describing the study and giving interested women telephone numbers to call (Appendix B).

Students and office personnel completed contact forms (Appendix C) on potential volunteers. When contact was initiated by students, only women's first names and telephone numbers were obtained to maintain relative anonymity. Names of friends and family members women thought might be willing to participate also were obtained. When permanent office staff received the contact sheets, they screened women listed on the forms and others who called to volunteer.

Screening consisted of obtaining women's birth date, presence and length of their relationship, household income, the number of people dependent on that income, and their race/ethnicity. Women not meeting the requirements were eliminated. In addition, Mexican Americans were asked whether they were born in this country. Only Mexican Americans were included rather than other Hispanics due to differences in socialization associated with other regions (Altarriba & Bauer, 1998; Cafferty & Chestang, 1976; West, Kantor, & Jasinski, 1998). Further, only women born in the United States or those who received at least 10 years of education in this country were included for two reasons. Immigrants may differ in unknown ways from native born women, and the use of rating scales would be relatively familiar only to fairly acculturated women. The ten immigrants had received all of their education in the United States. Women were also screened to eliminate those who were not poor.

Poverty status was established at screening and during the first interview by matching income from work and number in the household to the 1995 and 1996 Federal

poverty figures (Appendix D). Although these guidelines calculate poverty based on the size of the family unit and the family income from work (earnings) and public aid, the cash value of aid, determined in Wave 1 interviews, was not used until all women had been interviewed. Women reporting earnings greater than 175% of poverty were eliminated unless they were receiving assistance from a poverty program. Because women generally underestimated household income during screening, this was thought to allow for a final sample living within 200% of poverty. Percent of poverty level (including public aid) ranged from 0% to 399%. The 19 participants over 200% of poverty at the time of the first interview were receiving public assistance. Therefore, they were included in the study.

When women were qualified and agreed to participate, office workers obtained their full name and address prior to scheduling their first interview. Women were told that participation would require them to answer questions in four interviews, each of which would last approximately three hours, over two years. Additionally, they were told the incentives would increase for each succeeding interview. Participants were given a membership card as well as $15.00 in cash, two bus passes, and a "Project HOW" T-shirt and canvas tote bag in return for participation in Wave 1. Women received $35.00 in cash and bus passes to complete the second interview. Forty-five dollars and bus passes were given in return for Wave 3 interviews.

Interviewers. Data were collected using structured interviews conducted by university students. Due to the sensitive nature of many questions, only female students were used to increase rapport and comfort for participants. Interviewers received $17.00

for Wave 1, $20.00 for Wave 2, and $25.00 for Wave 3. Some interviewers also received psychology course credit for participation, others received course credit instead of pay, and other students volunteered their time, accepting neither payment nor course credit for their effort. Although all interviewers were eligible for payment, students who wished to be paid and receive course credit were required to schedule more interview times.

Interviewers were trained by four doctoral students in Clinical, Counseling, and Behavioral Medicine/Health Psychology. Standardization and confidentiality issues were stressed. In addition, a doctoral student went through the interview, item by item, explaining how each question should be asked and when to ask conditional questions. Trainees were then instructed to spend time practicing the interview aloud and role-playing with one another, friends, and family. When a student believed she was ready to begin interviewing, she was tested. For Wave 1, this procedure consisted of videotaping a role-play session with a doctoral student playing the part of a complex participant. After Wave 1, videotapes were not used, but the role-plays continued. The doctoral students assessed whether the student knew the interview, knew when to ask conditional questions, was able to handle extraneous questions and comments appropriately, adequately paced the questions, etc. If a student did not pass this part of the training, she continued practicing before returning for an additional role-play. This process was repeated until one or more of the doctoral students believed the interviewer was sufficiently competent to begin collecting data. Although many students quit the project during training, only one woman had to be told she would not be able to conduct interviews. Students' first two interviews were also checked in detail before releasing

interviewers from training. Continual feedback was given to the interviewers to ensure accuracy of the data. Through the first three waves, a total of 100 students conducted interviews.

Confidentiality. Strict procedures for confidentiality were devised for the study. A Certificate of Confidentiality was obtained from the Public Health Service to protect women's anonymity and the data they provided. With this certificate, neither women's names nor their answers could be released, even to a court of law, without an explicit written release from the participant.

Interviewers were instructed not to discuss the actual questions with office workers. Nor could they discuss participants' answers with anyone except other interviewers, the principal investigator, or the doctoral students in charge of data. Interviewers did not have access to identifying information, such as the participants' last names or addresses. In addition, interviewers and office staff were naive to the actual purposes of the study, hypotheses, and research questions. All students and employees of the study, with the exception of the principal investigator, statistician, and doctoral research assistants, were told the study was being conducted to better understand various factors in the lives of low-income women that impact their physical and mental health.

Full names, addresses, and telephone numbers were collected by the office staff. These women were responsible for following up with contact sheets and scheduling interviews. When a woman arrived for her interview, a registration form was completed to acknowledge informed consent and provide information to match subjects to their data (Appendix E). Women were given a copy of the informed consent information in two

ways. One was written in technical terms and hand signed by the principal investigator. In the other form, simple English was used and the information was organized into summary points. Permission to Contact forms facilitated retention (Appendix F). These forms listed individuals and sites (e.g., welfare, schools, and hospitals) through which women could be contacted. Interviewers were not allowed in the waiting area while participants were completing the forms to ensure that identifying information could not be overheard.

Office staff assigned participants a membership number that did not correspond to the subject numbers used to organize the data. These numbers, corresponding to their membership card, facilitated tracking. Only the doctoral student in charge of tracking participants and the principal investigator had access to both women's answers and the registration forms containing identifying information.

When interviews were received in the research room at the University of North Texas, subject numbers were assigned to the data. The master sheet matching participant codes, subject number, participant's names, and registration forms were stored in a locked filing cabinet at the University of North Texas. Except when taken to data entry, the interviews were kept in the research room. The completed interviews do not have information that identifies any individual.

Data collection. Interviews were conducted in two store front offices in the Oak Cliff area of Dallas, one of which was closed after Wave 1. The interviewer read all questions aloud and participants' verbal responses were recorded by interviewers. Answers usually consisted of a number from a rating scale in a notebook participants

used during the interview. Answers to some questions consisted of yes, no, or a brief verbal response.

When an interview reached the research room, a graduate student coded all time related questions for number of months, weeks, or days depending on the item. During Wave 1, when information indicated a participant did not meet the inclusion criteria, she was dropped from the study via a letter of notification. Moreover, participants unable to master the use of rating scales and those who were obviously intoxicated were dropped during the interview but were given the incentives. Of the 996 women interviewed, 160 were dropped from the study. The most frequent reasons for eliminating women at this stage were relationship and income related. The detailed information women provided during the interview indicated they did not meet study requirements.

Measures

The three interviews contained several measures and questionnaires for which rating scales were used. Only those related to the model being tested are described here. It was anticipated that many of the women would have less than a high school education. Therefore, care was taken to ensure their understanding. Modifications were made for three reasons. First, questions from different measures had to fit well to allow a reasonable pace to be set by the interviewers. Second, many instruments were originally developed for use by college students rather than less educated community dwelling people. Therefore, some items were adapted with minor wording changes and, at times, simplified to ensure understanding by participants. Third, some rating scales were

modified for consistency with other scales to less confusion for women unaccustomed to this type of task. The Appendices include original and modified wording of items.

Victimization. Victimization was measured as sustained physical violence, psychological abuse, and sexual assault inflicted by a woman's current partner. Violence inflicted by women's past partners and their parents, sexual assault by others and revictimization were also assessed.

An overall composite for revictimization was created to measure sustained aggression across types of Victimization and perpetrators. Women were given a score of one or zero for having sustained or not sustained, respectively, each type of Victimization measured. A composite was created by summing these figures. Higher scores were indicative of sustaining more types of Victimization.

Two types of sustained abuse from a woman's current partner were assessed with the Severity of Violence Against Women Scale (SVAWS; Marshall, 1992). The SVAWS, a 46 item measure which differentiates threats of violence, acts of violence, and sexual aggression, is listed in Appendix G. This measure was developed with a college sample consisting of 751 females, ranging in age from 17 to 72, as well as a community sample of 208 women, ranging in age from 19 to 75, who rated items on various measures of severity (e.g., how abusive, serious, threatening each act would be if a man inflicted it on a woman). Factor analysis using oblique rotation resulted in the emergence of nine factors distinguishing types and severity of physical violence. These nine factors represent threats of violence (symbolic violence, threats of mild, moderate, and serious violence), acts of violence (mild, minor, moderate, and serious), and sexual aggression.

The acts of violence and sexual aggression subscales were used in this study. For the three ethnic groups in this sample, Cronbach alpha ranged from .87 to .96 for partner violence and .74 to .89 for sexual violence. In Wave 1, women reported acts inflicted during their entire relationship on a rating scale ranging from never (0) to a great many times (5). In Waves 2 and 3, women reported acts inflicted since the previous interview on a rating scale ranging from never (0) to almost daily (9). A composite score for partner violence was created by summing standardized means for the 21 acts of violence from the three waves of interviews. The same procedures were used for the 6 sexual aggression items. Higher scores indicated more Victimization sustained but greater severity of acts of violence and sexual aggression cannot be assumed from higher scores.

Psychological abuse by women's partner was another type of Victimization measured. Based on a previous study, Marshall (1994) developed 184 items to represent 41 categories of behavior that could be psychologically or emotionally abusive. Both subtle (e.g., "somehow keep you from having time for yourself") and overt (e.g., "criticize something you did well or discount it") acts that may undermine a woman's sense of self and mental health were included. Marshall and Guarnaccia (1998) developed a preliminary version of the Men's Psychological Harm and Abuse in Relationship by eliminating acts that were too prevalent (i.e., sustained by more than 75% of the sample) or too rare (i.e., sustained by fewer than 15% of the sample). Women were told to report acts their partner had done in a loving, joking or serious way. They reported the frequency of each of the 65 acts in Appendix H on a scale anchored by never (0) and almost daily (9). For this sample, internal consistence, as measured by Cronbach alphas,

was high with no alpha below .98. A composite score for partner psychological abuse was created by summing the means from all three waves. Higher sums indicated more psychological abuse.

Victimization in the family of origin and earlier relationships with men were also assessed. Items were developed from the physical aggression subscale of the Conflict Tactics Scale (Straus, 1979) with the addition of "choked," as included in Straus and Gelles's (1985) Second National Family Violence Survey. The modifications were on the response scale and differentiating items that included more than one act which may differ in severity as shown in Appendix I. Women reported how many times past partners and parental figures inflicted each act using a 6-point scale anchored by never (0) and a great many times (5). The mean of the 11 items represented violence sustained from parents in the family of origin and past partners. Cronbach alphas for this sample ranged from .91 to .93 for family of origin and .95 to .97 for past partner violence. Higher means indicated more physical violence sustained but more severe violence cannot be assumed from higher scores.

Sexual assault perpetrated by past partners, dates, and someone other than a partner was also assessed. These measures consisted of the five acts of sexual aggression listed in Appendix J. For each act, a severity weight was assigned ranging from one to five with higher numbers indicating more severe coercion. Severity weights for no past victimization (0), touching or fondling (1), or engaging in a sexual act through the use of verbal coercion (2), threats of physical force (3), physical force (4), or a weapon (5) were used as multipliers. Women reported the actual number of incidents of each act they

sustained throughout their lives. A score for each act of sexual assault was created by multiplying the number of incidents by its severity weight. The five scores were then summed to create a composite measure of sexual assault. Being touched or fondled by past partners and dates was not included due to the high frequency with which it likely occurs.

Several types of information on sexual assault were available to check for reporting or coding errors. This information included the relational identity and gender of the perpetrator, age at the first and last assaults, and the duration from the first to the last assault by the first and final perpetrators. Sixty- six women reported having sustained one or more of the five acts of sexual assault 10 or more times.

These interviews were reviewed to determine whether one experience was reported in more than one category. A perpetrator could use both threats and acts of violence during the assault. Women may have reported this incident for both questions, despite explicit instructions to the contrary. Eight women had reported more than one type of sexual coercion by the same perpetrator, during the same time frame with the same number of incidents. Therefore, the number of incidents for the lesser act of sexual coercion was deleted. For example, if a woman reported her uncle used both threats of physical force and physical force 50 times each from the age of 5 to 15, the number of incidents for threats of physical force was changed to zero because these acts were already counted under the use of physical force. Only when the data were identical for multiple types of assault were they changed.

Overreporting was the second type of error investigated. Given the general consensus that sexual assault is relatively rare, the possibility of overreporting was considered. The interviews confirmed the number of incidents for the remaining 58 women with a score over 10 or sufficient information was not available to make a decision regarding overreporting. For example, one participant reported she was victimized by use of force three times per month for 9 years by the same perpetrator. Thus, her data was not changed due to the apparent accuracy in her perceptions for the number of incidents. Either confirmatory information was obtained or insufficient information was available to determine the accuracy of the data for 54 women. One participant stated that she was including her ex-boyfriend in the information on dating. This data was deleted from dating assault.

Coping Resources. Coping was conceptualized as women's intrapersonal and interpersonal resources. The intrapersonal indicators were optimism, self-esteem and private self-consciousness. Interpersonal indicators of coping were social network and psychotherapy.

Optimism was measured using the revised (Scheier, Carver, & Bridges, 1995) Life Orientation Test (Scheier & Carver, 1985b). As shown in Appendix K, the six statements assessed generalized expectations for positive versus negative outcomes. Cronbach alpha was .82 for the revised scale with the original sample of college students. Cronbach alphas for this sample ranged from .33 (Mexican Americans) to .65 (Euro-Americans). Although the internal consistency was low, the wide use of this measure with a variety of populations justified its inclusion. Participants rated their agreement

with each statement on a 6-point scale from strongly disagree (1) to strongly agree (6). Embedding these items with others eliminated the need for four filler items. High means were a positive indicator of Coping.

Rosenberg's (1965) Self-Esteem scale was the second indicator of intrapersonal Coping. The 10 items in Appendix L have been used extensively with a wide variety of adult samples. This measure yields a general judgment without reference to specific domains of functioning. The original 4-point scale anchored by strongly disagree (1) and strongly agree (4) was modified to reflect the degree to which women felt self-acceptance and self-worth using a 7-point scale anchored by completely false/I'm never like this (1) and completely true/exactly like me (7). Rosenberg reported a test-retest coefficient of .92 and a scalability coefficient of .72. Cronbach alpha for this sample ranged from .83 to .84. A high mean was a positive indicator of Coping.

A third indicator of Coping, private self-consciousness, was measured using a revision (Scheier & Carver, 1985a) of the Private Self-Consciousness Scale (Fenigstein, Scheier, & Buss, 1975). Seven items assessed women's propensity towards introspection and monitoring of internal reactions. The revision simplified items to allow individuals with little education to have the same understanding as a college population. The revised and original scales were strongly correlated ($\underline{r}$ = .82), and Cronbach alpha was higher (.75) than the original measure (.69) with the original samples. Due to a low item-total correlation for this sample, an additional item was dropped ("I never take a hard look at myself"). Following this modification, alphas ranged from .64 to .71. The original response scale, not at all like me (0) to a lot like me (3) was also changed to a 7-point

scale anchored by completely false/I'm never like this (1) and completely true/exactly like me. The items are listed in Appendix M. A higher mean on this positive indicator reflected a greater propensity toward introspection and reliance on internal rather than external factors for Coping.

Two interpersonal Coping resources were also included, social support network and psychotherapy. Social support, the fourth indicator of Coping, was operationalized as the perceived size of women's social network which contained the number of others women believed they could turn to in times of need and in a variety of situations. It was assessed using items derived from the Social Support Questionnaire (Sarason, Sarason, Shearin & Pierce, 1987), Belle (1982c), and Tan, Basta, Sullivan & Davidson (1995). For each of the 11 items describing different types of tangible and intangible support, in Appendix N, women reported the number of people available to provide that type of support. After responding to all items prompting them to think about their network in a variety of ways, women reported the total number of different people in their network. Thus, the size of women's social network was a positive indicator of Coping in that having a larger social support network implies the potential for more effective coping.

Finally, utilization of psychotherapy was the fifth indicator of Coping. Questions were developed to assess for use of psychotherapeutic resources as a means of positive Coping. Women reported the number of times they had sought counseling or psychotherapy.

Openness. Interpersonal Openness was conceptualized as the ability to form, maintain, and benefit from relationships with others. Six indicators were used.

Jack and Dill's (1992) Silencing the Self was a negative indicator of Openness. Self-silencing was one of four rationally derived subscales assessing factors associated with depression. The 9 items on this subscale assessed women's tendency to inhibit self-expression. As shown in Appendix O, the original items referred to both the partner and others. For consistency, the items were modified to refer to people in general. Women rated their agreement with each statement on a 6-point scale anchored by strongly disagree (1) and strongly agree (6). In the original study with a sample from a battered women's shelter, Cronbach alpha for the subscale was .90 with strong test-retest reliability ($\underline{r}$ = .93). Cronbach alphas for this sample ranged from .72 to .82. A high mean indicated women's tendency to refrain from disclosure of thoughts and feelings.

The Communal Orientation Scale, developed by Clark, Oullette, Powell, and Milberg (1987), was the second indicator of Openness. This measure assessed the tendency to believe that people should be sensitive and receptive to the needs of others. Two of the 14 items ("It bothers me when other people neglect my needs" and "When I have a need, I turn to others I know for help") were not included due to low factor loadings (.29 & .38, respectively) and item-total correlations (.23 & .30, respectively) in the original study. The remaining items are listed in Appendix P. Women rated how true each statement was for them on a 7-point scale anchored by completely false/I'm never like this (1) and completely true/exactly like me (7). In the original sample of college students, internal consistency was .78. For this sample, Cronbach alpha ranged from .61 to .68. Higher means provided a positive indicator of Openness.

Interpersonal trust was an indicator of Openness. Larzelere and Huston's (1980) Dyadic Trust Scale measured trust in interpersonal relationships and was used. The scale was used two ways, to assess women's trust of their partner and friends. One of the eight items ("I feel that I can trust my partner completely") was not used because it was an extreme statement. The items in Appendix Q indicate both versions of the instrument. Women rated their agreement with each statement on a 6-point scale ranging from strongly disagree (1) to strongly agree (6). In the original sample of college students, internal consistency was .93. Cronbach alphas for this sample ranged from .84 to .91 for trust in partner and .77 to .81 for trust in friends. High means indicated high levels of trust in others and Openness.

Self-monitoring was used as a negative indicator of Openness. Lennox and Wolfe (1984) and Wolfe, Lennox, and Culter (1986) reassessed Snyder's (1979) measure of self-monitoring. Their Concern for Appropriateness subscale, measuring the tendency to protect oneself during interactions, was utilized in this study (Appendix R). This subscale assessed protective variability and protective social comparison, the tendency to tailor actions to avoid the disapproval of others. Women rated how true each statement was for them using a 7-point scale anchored by completely false/I'm never like this (1) and completely true/exactly like me (7). In the original sample, Cronbach alpha was .86. For this sample, it ranged from .77 to .85. A high mean indicated self-protection in disclosure of experiences, values, and opinions across situations.

The Network Orientation Scale (Vaux, Burda, & Stewart, 1986) was the final indicator of Openness. The 20 items assessed a willingness to seek social support from

available people, self-disclosure, and trust that others will provide the desired support (Appendix S). Three items ("You have to be careful who you tell personal things to." "It's fairly easy to tell who you can trust, and who you can't." "In the past, I have been hurt by people I confided in.") were excluded due to low correlations (.08 to .16) with the total scale in the original sample of nonstudent adults. Women rated their agreement with each statement on a 6-point scale from strongly disagree (1) to strongly agree (6). Cronbach alpha was .60 and test-retest reliability was high ($\underline{r}$ = .85) with the original student sample. Cronbach alpha ranged from .69 to .77 for this sample. High means indicated Openness to receiving support from others.

Psychological Symptoms. To assess emotional distress, it was necessary to measure a broad range of symptoms. The three indicators were a global measure of distress, suicidal ideation, and dissociation. These measures provided a comprehensive assessment of Psychological Symptoms.

The original version of the Symptom Checklist (SCL-90; Derogatis, Lipman & Covi, 1973) was used as a positive indicator of Psychological Symptoms. The global distress scale provided the broadest assessment of psychological distress including anxiety, depression, hostility, interpersonal sensitivity, obsessive-compulsive behavior, paranoid ideation, phobic anxiety, psychoticism, and somatization. The 90-item scale and minor modifications of it (e.g., Hopkin's Symptom Checklist; Derogatis, Leonard, Lipman, Rickels, Uhlenhuth, & Covi, 1974a, 1974b; and the SCL-90R, Derogatis, 1976) have been widely used with both community and clinical samples. Women rated how much they were bothered by each symptom during the past month on a 5-point scale

anchored by not at all (0) and extremely (4). This time frame was chosen to obtain a report of relatively long-term symptoms and have a baseline against which to assess changes in later waves of interviews. Cronbach alpha for all groups in this sample were .98. A high mean indicated greater distress.

The second indicator of Psychological Symptoms was suicidal ideation measured by five of the seven items on the severe depression subscale of the General Health Questionnaire (Goldberg & Hillier, 1979). The scale assessed women's tendencies to contemplate suicide. This measure was developed on a British sample, so one item was reworded as can be seen in Appendix T. Two items ("Been thinking of yourself as a worthless person" and "Found at times you couldn't do anything because your nerves were too bad") were omitted. Participants rated each statement on a 7-point scale from never (1) to very often (7). Cronbach alpha for this sample ranged from .89 to .92. A high mean was a positive indicator of Psychological Symptoms.

The third and final indicator of Psychological Symptoms was dissociation. Briere and Runtz (1990b) recognized the SCL-90, HSCL-90, and SCL-90R were inadequate for measuring the dissociative symptomology that may result from sexual assault trauma. Therefore, they devised the 13-item Dissociative Scale (Appendix U) to assess the cognitive disengagement from aversive stimuli that often occurs during and after an assault through numbing of emotions and responses. The measure was normed on college women with internal consistency ranging from .85 to .90. For this sample, Cronbach alphas ranged from .92 to .95. Women rated their agreement with each statement on a 5-

point scale anchored by not at all (0) and extremely (4). A higher mean represented greater Psychological distress.

Analyses

This study tested the model in Figure 1 addressing whether Openness partially mediates the effects of Victimization on Coping and whether Coping mediates the relationship between Victimization and Psychological Symptoms. The latent constructs (Victimization, Openness, Coping, and Psychological Symptoms) were measured by the indicators shown the Figure. Each indicator and construct was assigned a plus or minus to show the expected direction of effect. Ethnicity was considered a moderating variable. Consequently, the measurement models and final Structural Equation Models (SEMs) were developed separately for each ethnic group.

Data analyses proceeded on several stages. First, a MANOVA was calculated for the indicators in each construct with follow-up AVOVAs and Student-Newman-Keuls procedures to determine which ethnic groups differed significantly from each other. This, coupled with descriptive statistics and correlation matrices, allowed the investigator to obtain an overview of the data.

There are three common preliminary steps for SEM were conducted. These were examining the indicators for normality, addressing the possibility of multicollinearity, and assessing for multivariate kurtosis. These steps are important for accurate model evaluation. First, data sets in social and behavioral sciences are seldom normal (Micceri, 1989). Consequently, methods such as the normal theory maximum likelihood (ML) have been developed to give consistent parameter estimates for a variety of distributions.

However, given the excessive kurtosis often found in these types of data, estimates by this method are generally not sufficient, according to Yuan, Chan, and Bentler (2000). A sample covariance matrix is efficient only when data are normal. With influential cases or outliers in a sample, the covariance matrix often is either inefficient or biased. Thus, any statistical method that utilizes a covariance matrix, such as the normal theory often used in SEM, will inherit the problem of inaccurate model evaluation, such as biased parameter estimates and incorrect test statistics. Scores considered to be outliers are often dropped or reassigned values that deviate less from the mean.

Second, multicollinearity occurs when intercorrelations among variables are so high that certain mathematical operations are either impossible or the results would be unstable. Multicollinearity can reflect separate variables that are actually measuring the same thing (Kline, 1998). Multivariate normality meets the assumptions that all univariate distributions are normal, the joint distribution of any combination of the variables is normal, and all bivariate scatterplots are linear and homoscedastic. Third, multivariate kurtosis is often examined with Mardia's Kappa coefficient (Mardia, 1970). In samples with large kurtosis, as was found in this data, a robust estimation technique should be used.

Eliminating or truncating outliers increases normality. However, these methods may result in an unrealistic perspective of the phenomenon because it eliminates extreme cases which are often important for understanding. To achieve better performance in SEM through decreasing the nonnormality, multicollinearity, and multivariate kurtosis of the data, robustification transformations were considered. If the data were problematic, in

terms of normality or kurtosis, the procedures outlined by Yuan et al., (2000) would be used. For data sets with outliers, robust estimation of the population covariance matrix has been studied and recommended by a variety of authors (Hampel, Ronchetti, Rousseeuw, & Stahel, 1986; Huber, 1981; Wilcox, 1997). By giving proper weight to each case, the influence of outliers on normality can be minimized without eliminating or minimizing their contribution to the sample matrix. These procedures allow keeping the type of extreme cases likely to be found in a community sample because of their importance for theoretical purposes. Mardia's multivariate skewness and kurtosis statistics could then be used to evaluate the degree of normality of the transformed data. Because the transformation makes the data approximately normal, applying the classical normal theory based procedures to the transformed data gives more efficient parameter estimates. This technique proved to be effective, using the initial tuning constant a=.82. The result was normally distributed indicators while eliminating the multivariate kurtosis found in the nontransformed sample data.

A robust estimation process transforms sample data into more normally distributed estimates by decreasing the multivariate skewness and kurtosis of the distribution. The procedure outlined by Yuan et al. (2000) downweighs the influence of data outliers through creating more eliptically distributed data matrices. This robustification procedure transformed the residuals in the data covariance matrix using the Mahalanobis distance for each data point in a Huber-type weight function to create initial weights that were used to downweigh outliers. An iteratively reweighed least squares algorithm was used to obtain convergence between the covariance estimates

through minimization of the residuals in the covariance matrix. That is, there are varying degrees of precision of measurement associated with each data observation, known as the Mahalanobis distance. By using this measure of distance, and a tuning constant or alpha (a) value chosen based upon the degrees of freedom for the data, the robustification process created an initial weight associated with each observation. The alpha value provided the constant in the Huber function that decreased the weight given to outliers in the covariance matrix. During the robustification procedure, the covariance matrix was iteratively reweighed until the parameter estimates of the final and most recent covariance estimates converged. This provided the best possible weights for each observation to minimize multivariate skewness and kurtosis.

After these robustifaction steps, measurement models for each construct were developed using Confirmatory Factor Analyses (CFA) separately for each ethnic group. The indicators for each construct (Victimization, Coping, Openness, and Psychological Symptoms) were submitted to factor analyses to ensure only one underlying dimension was addressed by the indicators. An iterative process was used in which indicators were dropped when factor loadings were low, and the indicator did not contribute positively to the overall goodness of fit of the factor or model. Factor matrices were then recalculated until they became acceptable. After all measurement models were developed for each construct, model development occurred also using an iterative process, testing and revising pathways between the constructs.

SEM, a combination of factor analysis and path analysis, was used to test the proposed model. It is an a priori statistical technique in which the model is provided at

the beginning of analyses that is utilized to test whether or not a theory is supported by the data (Kline, 1998). SEM procedures allow for simultaneous testing of various relationships and testing at a higher level of abstraction by differentiating latent and observed variables. Since no statistical measure is free from error, an error component is associated with each observed variable. SEM makes it possible to address the goodness of fit of the proposed model with data from each ethnic group.

Large samples are necessary for SEM procedures. Samples of less than 100 are considered small, 100-200 are medium, and over 200 are thought to be large. Thus, there were sufficient numbers of women in each ethnic group to allow for these procedures. In large samples, the generalized likelihood ratio (G^2) is interpreted as a chi-square ($?^2$) statistic with degrees of freedom that are equal to the difference between the number of observations and parameters (Kline, 1998). The $?^2$ statistic may be significant although differences between the observed and model-implied covariances are slight when utilizing large samples. To reduce this sensitivity, the $?^2$ value is divided by the degrees of freedom and a value of 3 or less is considered acceptable (Kline, 1998).

Goodness of fit for the model was tested using the Bentler Comparative Fit Index (CFI; Bentler, 1990). The CFI value designates the proportion in the improvement of the overall fit of the proposed model relative to the null model. For example, a CFI of .90 indicates that the fit of the proposed model is 90% better than the null model. Values of .90 are considered good. A value of 1 is considered excellent, although rarely seen.

The Standardized Root Mean Squared Residual (SRMR) provides a standardized summary of the average covariance residuals. SRMR also was utilized to assess goodness

of fit. Covariance residuals represent the differences between the observed and model implied covariances. A SRMR value of zero indicates a perfect fit between the data and the model. The value of SRMR increases as the average discrepancy between the predicted and observed covariances increase. An acceptable fit of SRMR is a value below .10 with a value of .05 considered to be good. EQS software (Bentler, 1995) was used to analyze model fit using the maximum likelihood estimation method.

Both the Lagrange Multiplier (LM) and the Wald statistic (W) were utilized while developing the final models. This process allowed for model trimming and building within theoretical constraints. The Lagrange Multiplier tested model fit if a particular parameter was added. This index approximates the value by which the model's overall $?^2$ would decrease if a particular parameter were freely estimated. The Wald statistic was also utilized for model trimming. The W statistic was used to estimate the degree to which the model's overall $?^2$ would decrease if a particular free parameter were fixed to zero (i.e., dropped from the model). The simplest forms of the models were first tested. Based upon the observed goodness of fit indices, suggested modifications were considered.

CHAPTER IV

RESULTS

Ethnic Differences

Multivariate Analyses of Variance (MANOVAs) were utilized to examine ethnic differences, as is often done in the literature. Separate MANOVAs were conducted on indicators for each construct. The results of follow-up univariate analyses (ANOVAs), with post hoc group differences tested using Student-Newman-Keuls procedures, are reported in Table 1. The MANOVA on victimization was significant, $F(14,1208) = 3.32$, $p < .001$ with univariate effects on past partner violence, $F(2,611) = 6.13$, $p < .002$, partner sexual aggression, $F(2,611) = 5.88$, $p < .003$, and revictimization, $F(2,611) = 6.97$, $p < .001$. These groups did not differ of family of origin violence, $F(2,611) = 2.70$, $p < .07$, past sexual assault, $F(2,611) = 2.86$, $p < .06$, partner violence, $F(2,611) = 1.51$, or partner psychological abuse, $F(2,611) = 1.10$. Euro-Americans reported sustaining more past partner violence and revictimization than either African Americans or Mexican Americans. However, African Americans reported more partner sexual aggression than the other groups.

The MANOVA on coping was significant, $F(10,1232) = 8.06$, $p < .001$, with univariate effects on optimism, $F(2,621) = 14.42$, $p < .001$, self-esteem, $F(2,621) = 8.98$, $p < .001$, private self-consciousness, $F(2,621) = 11.56$, $p < .001$, and therapy, $F(2,621) = 6.86$, $p < .001$. There was no difference on social network, $F(2,621) = .04$. All groups differed on optimism with African Americans the most and Euro-Americans the least

optimistic. African Americans also were higher in self-esteem and private self-consciousness than the other groups. Euro-Americans reported more therapy than women of color.

The MANOVA on openness was significant, $F(12,1232)=3.18$, $p < .001$, with univariate effects on self-monitoring, $F(2,622) = 6.74$, $p < .001$, and network orientation, $F(2,622) = 7.95$, $p < .001$. The groups did not differ on self-silencing, $F(2,622) = 1.15$, communal orientation, $F(2,622) = 1.87$, trust in friends, $F(2,622) = .19$, or trust in partner, $F(2,622) = 1.53$. Mexican American women were lower in self-monitoring than African Americans or Euro-Americans. Euro-Americans reported stronger network orientations than African Americans or Mexican Americans.

The MANOVA on psychological symptoms was not significant $F(6,1238)=.38$. No univariate effects were found.

Correlations

Correlations for the sample and each ethnic group were calculated. Correlations were expected to be higher within measures of the same construct than between measures of different constructs. When higher correlations are found between measures of different constructs, multicollinearity may exist. As one check for multicollinearity, correlation matrices were calculated using the original, nonrobust data for the entire sample and each ethnic group. These matrices are reproduced in Tables 3 (sample), 4 (African Americans), 5 (Euro-Americans), and 6 (Mexican Americans).

Across the groups, higher correlations were found between indicators for the Victimization and Psychological Symptoms constructs than for Coping or Openness.

Self-esteem was negatively correlated with the three measures of Psychological Symptoms, and these relationships were relatively strong. Psychological abuse was also moderately to highly negatively associated with both self-esteem and trust in partner. Self-monitoring was positively correlated with global distress. The low correlations for past partner violence, family of origin violence, and past sexual assault with the indicators of Psychological symptoms were also noteworthy.

Thus, there was no clear multicollinearity problem for African Americans, Euro-Americans, or Mexican Americans because the strongest correlations were between different indicators of the same construct. Despite the presence of a few cross-construct correlations over .55, multicollinearity was determined not to be a sufficient problem with groups of this size.

Correlation matrices for the robustified data are shown for African Americans (Table 6), Euro-Americans (Table 7) and Mexican Americans (Table 8). The pattern of relationships among the variables remained intact. Almost all correlations did not deviate more than .01 between nonrobustified and robustified data. Across the groups, the largest changes were .07 for African Americans (optimism with trust in friends and with self-monitoring). Consequently, it appears that robustification preserved the inter-relationships.

Model Testing

African Americans. Confirmatory Factor Analysis (CFA) was used for measurement modeling with data from 245 African American women. The final results are reported in Table 9. The Victimization measurement model did not differ

significantly from the data, χ^2 (10) = 13.28, p = .23, and had a good fit according to the Comparative Fit Index, CFI = .99. The Coping measurement model, χ^2 (1) = .075, p = .78, fit the data well (CFI = 1.00) following the removal of the therapy indicator due to low loading (.004). The Openness, χ^2 (4) = 4.35, p = .37, measurement model did not differ significantly from the data and demonstrated good fit (CFI = .99) following removal of communal orientation due to low loading (.094). Finally, the CFI was 1.00 for Psychological Symptoms. Thus, the only changes from the model to be tested were that therapy was dropped from Coping and communal orientation from Openness.

The initial structural model was significantly different from the data, χ^2 (151) = 586.54, p = .001, and demonstrated poor fit (CFI = .712). Several modifications were made based on minor contributions and low factor loadings. The optimism indicator of Coping and trust in friend indicator of Openness were removed due to low factor loadings (.065 and –.162, respectively) which increased the fit of the model (CFI = .847). Next, the LM test suggested adding a parameter from the Victimization indicator of psychological abuse to Openness. That is, psychological abuse functioned as an indicator of Openness as well as Victimization. When this change was incorporated, the fit increased (CFI = .859). To test mediation of Victimization by Openness, which would be more parsimonious, the Coping construct was removed. A parameter was also added between Victimization and Psychological Symptoms to assess the direct path of influence in addition to the mediating influence of Openness. These modifications resulted in a good fit using the CFI (.993) and the SRMR (.046) measures. When all modifications were incorporated into the model, it did not differ significantly from the data, χ^2 (62) =

64.57, p = .38. Furthermore, when adjusted for sample size, the model fit was acceptable (χ^2/df = 1.04). Openness partially mediated the effects of Victimization on Psychological Symptoms for African American women. The model accounted for 50.5% of the variance in African American women's Psychological Symptoms.

The 1.00 loading for revictimization should be noted. Findings such as this one are known as the Heywood case. This can arise through sampling fluctuations or a misspecified model (Dunn et al., 1993). The situation can be handled by releasing the constraints on the error variance associated with the indicator, thereby allowing for the emergence of a negative error variance or interpreting the results with caution. The second approach was chosen.

Euro-Americans. The results of measurement modeling for 185 Euro-Americans are shown in Table 10. The Victimization, χ^2 (1) = 1.30, p = .25, measurement model did not differ significantly from the data and demonstrated good fit (CFI = .99) following the removal of the past partner violence, family of origin violence, and past sexual aggression due to low loadings (.204, .232. and .106, respectively). The Coping, χ^2 (2) = .77, p = .70, measurement model fit the data well (CFI = 1.00) after therapy was dropped as unrelated (.001). The Openness, χ^2 (8) = 10.66, p = .23, and Psychological Symptoms measurement models both demonstrated good fit (CFIs = .93 and 1.00, respectively). Thus, differences from the proposed model for Euro-Americans were dropping past partner violence, family of origin violence, and past sexual aggression from Victimization and therapy from Coping.

The initial causal model differed significantly from the data, χ^2 (114) = 244.67, p < .001, and had a poor fit, CFI = .824, until modifications were implemented. The trust in friends indicator of Openness was eliminated due to a low factor loading (.096) which resulted in an increase to CFI = .898. Coping was dropped due to low factor loadings (< .300) for all indicators except self-esteem which loaded as a negative indicator (-.756). A parameter was also added between Victimization and Psychological Symptoms to assess the direct influence of Victimization on Psychological Symptoms without the mediating influence of Openness. This parsimonious modification increased the fit of the model (CFI = .927; SRMR = .080). In addition, a modification suggested by the LM test resulted in a better fit. A parameter was suggested between the Victimization indicator partner psychological abuse and Openness. When psychological abuse was added as an indicator of Openness, the fit was increased (CFI = .994, SRMR = .043). The final model did not differ significantly from the data, χ^2 (40) = 42.13, p < .27. When adjusted for sample size, the model fit was acceptable (χ^2/df = 1.05). Similar to African American women, Openness partially mediated the relationship between Victimization and Psychological Symptoms for Euro-American women. The final model accounted for 50.9% of the variance in Psychological Symptoms.

Mexican Americans. Measurement modeling was conducted using data from 202 Mexican Americans. The results are shown in Table 11. The Victimization measurement model did not differ significantly from the data, χ^2 (3) = .81, p = .85, and demonstrated good fit (CFI = 1.00) following removal of the family of origin violence and past sexual assault indicators due to low factor loadings (.272 and .214, respectively). The Coping, χ^2

(1) = .34, p = .85, measurement model did not differ significantly from the data showing a good fit (CFI = 1.00) following the removal of the therapy indicator due to low loading (-.010). The Openness, χ^2 (5) = 6.98, p = .19, measurement model was a good fit (CFI = .94) following the removal of trust in friends due to low loading (.077). The Psychological Symptoms measurement model had good fit (CFI = 1.00). Thus, the differences from the proposed model were eliminating family of origin violence and past sexual assault from Victimization, therapy from Coping, and trust in friends from the Openness construct.

The causal model results were quite different for Mexican Americans. Initially, the model differed significantly from the data, χ^2 (115) = 286.66, p < .001, and was a poor fit, CFI = .861. Due to low factor loadings, the Coping indicators of optimism (-.060) and social network (.162), the Openness indicator communal orientation (.197), and the Victimization indicator family of origin violence (.259) were eliminated from the model. This increased the fit (CFI = .934; SRMR = .077). To assess for partial mediation and the most parsimonious model, the Coping construct was eliminated. When this modification decreased model fit (CFI = .872), it was reversed. Next, the parameter between Victimization and Coping was eliminated. This modification increased model fit (CFI = .952, SRMR = .067). The LM test suggested a parameter from the Openness indicator of trust in partner to Victimization should be added. When trust in partner was added as an indicator of Victimization, the model demonstrated good fit (CFI = .994, SRMR = .042). The model did not differ significantly, χ^2 (55) = 61.46, p = .27, from the data. When adjusted for sample size, the model fit was acceptable (χ^2/df = 1.12).

Openness mediated the effects of Victimization on Coping and Psychological Symptoms. The model accounted for 80.3% of the variance in psychological symptoms among Mexican American women.

CHAPTER V

DISCUSSION

This study tested a model that proposed Openness would partially mediate the effects of Victimization on Coping, while Coping mediated the Victimization-Psychological Symptoms relationship. Among African Americans and Euro-Americans, the most parsimonious model showed Openness largely mediated the Victimization-Psychological Symptoms relationship. In contrast, the proposed model fit the data for Mexican Americans, except that Openness fully mediated the Victimization-Coping relationship.

This study extended previous research on the use of coping to minimize the psychological distress associated with negative life events (e.g., Horowitz & Bordens, 1995) by introducing the notion that interpersonal Openness would mediate the victimization-distress relationship. Previous research assessed the utilization of interpersonal and intrapersonal coping resources to minimize the impact of interpersonal violence (Arata, 1999; Arata & Burkhart, 1998; Bergen, 1995; Frazier & Burnett, 1994; Heron, Twomey, Jacobs, & Kaslow, 1997; Lempert, 1996; Neville & Heppner, 1999; Ornduff & Monahan, 1999; Rabin, Markus, & Voghera, 1999; Regehr, Marziali, & Jansen, 1999; Scott-Gilba, Minne, & Mezey, 1995; Ullman, 1996; Valentiner, Foa, Riggs, Gershuny, 1996). The literature had not examined how victimization may affect openness and how openness would affect the victimization-coping-distress relationship.

Furthermore, this study broadened the literature by addressing ethnic differences in ways women cope with victimization. Research generally compares minority groups to Euro-Americans. One assumption underlying these comparisons is that members of ethnic minorities groups are more similar to each other than they are to Euro-Americans. The findings of this study suggest that such assumptions should not be made. Differences between the three models support the notion that minority groups are not as homogenous as often assumed. Ethnicity was modeled as a moderating variable. Testing one robust model across groups would not have adequately represented any of the three ethnic groups. Further, the resulting composite would not have allowed recognition of the similarities between the models for African Americans and Euro-Americans, and would have obscured the very different model found for Mexican Americans.

Interesting ethnic differences emerged for how women reduce the Psychological Symptoms resulting from interpersonal Victimization. When Openness was included in the victimization-distress model, Coping resources were not important for African Americans and Euro-Americans. Openness partially mediated the relationship between Victimization and Psychological Symptoms in these groups. In contrast, the proposed model was quite similar to the final model for Mexican Americans. Openness mediated the relationship between Victimization and women's Coping resources. The effects of Victimization on Psychological Symptoms were completely mediated by Openness and Coping, respectively. The final model for Mexican Americans accounted for 29% more of the variance than the model for the other groups. Thus, the model for Mexican Americans was most complex.

The path from Openness to Psychological Symptoms was hypothesized to be indirect through interpersonal and intrapersonal Coping resources. Supporting the proposed model, the victimization-distress relationship was mediated by Coping resources for Mexican Americans. However, only intrapersonal Coping resources were important in the final model. In contrast, neither interpersonal nor intrapersonal Coping emerged as useful in the models for African Americans and Euro-Americans.

Ethnic similarities and differences were found for each of the constructs. The three types of victimization by women's current partners were important across the sample, as was the number of different types of victimization women had sustained. Only for African Americans did the three types of past victimization (past partner violence, family of origin violence, and past sexual assault) remain in the final model. Early victimization (Browne & Finkelhor, 1986a; Cloitre et al., 1996; Goodman & Fallon, 1995; Herman & Hirschman, 1981; Irwin, 1999; Messman & Long, 1996; Miller et al., 1978; Rennison & Welchans, 2000; Russell, 1986; Sappington et al., 1997; Weaver et al., 1997), especially in the family of origin (Aldarondo & Kantor, 1997; Bernard & Bernard, 1983; Breslin et al., 1990; Cappell & Heiner, 1990; Hotaling & Sugarman, 1986; Irwin, 1999; Kalmuss, 1984; Laner & Thompson, 1982; Malone et al., 1989; Steinmetz, 1977; Straus et al., 1980), or sexual assault (Atkeson et al.,, 1989; Briere, 1992b; Mahoney; 1999; Mandoki & Burkhart, 1989; Marhoefer-Dvorak et al., 1988; Miller et al., 1978; Russell, 1986; Tjaden & Thoennes**,** 1998; Urquiza & Goodlin-Jones, 1994; Wyatt et al., 1992; Wyatt & Riederle, 1994), has been found to be a risk factor for later victimization. These findings did not support past research on the long-term effects of prior

victimization on psychological symptoms (Carey, 1997; Dutton, 1992b; Egeland et al., 1983; Famularo et al., 1994; Famularo et al., 1992; Fernández-Esquer & McCloskey, 1999; Herman, 1992; Kaufman & Cicchetti, 1989; Kiser et al., 1991; Livingston et al., 1993; Malinosky-Rummell & Hansen, 1993; Martin & Elmer, 1992; Stalker & Davies, 1995; van der Kolk et al., 1996; Walker, 1979, 1984) except for among African Americans. The appearance of revictimization in the final models partially supported earlier findings. However, it was also apparent that all types of past victimization exerted a long-term impact on African Americans in ways not evident for Euro-Americans or Mexican Americans. Reasons for this African Americans vulnerability to psychological distress are not evident. Perhaps women of African descent conceptualize past victimizations such that the type of aggression sustained remains important, while Euro-Americans and Mexican Americans, although still influenced by the experience of past victimization, do not attend to the type of past victimization experienced as much as the presence of multiple victimizations within their lives.

Interestingly, trust in partner emerged as a negative indicator of Victimization for women of Mexican descent. Indeed, it made a stronger contribution to Victimization than to Openness. This finding may be an outcome of the cultural importance placed on loyalty, harmony, and solidarity in familial relationships (APA, 1993) and the subservient nature of the female role in intimate relationships (Miller, 1978; Peñalosa, 1968) in Mexican American culture. For women to assume and maintain loyalty and submissiveness with a partner, they likely must trust the individual to whom they defer (de Leon, 1993). The relationships of African Americans and Euro-Americans are more

egalitarian (de Leon, 1993; Harris, 1996; Miller, 1978; Roschelle, 1997) with these women being less submissive. Consequently, their trust in partners is not as closely tied to victimization. The close connection among women of Mexican descent, therefore, may be due to the nature of intimate relationships in their culture.

As expected, the path between Victimization and Openness was negative and relatively strong for all three groups. Thus, as Victimization increased, women's Openness to interpersonal relationships decreased. Unfortunately, this inverse association suggests women lose some access to a factor that could help diminish the psychological impact of sustained aggression. This loss is strongest for Euro-Americans and weakest for African Americans. Perhaps the strong familial bonds found in the African American (APA, 1993; Kochman, 1981; Ting-Toomey, 1986) and Mexican American (APA, 1993; Levy, 1988; Marin & Marin, 1991; Miller, 1978; Peñalosa, 1968) communities and the potential to rely upon family members during times of stress may decrease the negative impact of Victimization on Openness for women of color. Thus, Euro-American women of low SES may be less embedded in family, social, and community networks. Consequently, these women may be more isolated in general and feel less able to turn to others in times of need. Victimization may harm their Openness to interpersonal relationships, especially if they are high in communal orientation, an indicator found related to Openness only among Euro-American women. Communal orientation may be a cultural value related to interpersonal openness only in Euro-American society. Those high in communal orientation believe they should be sensitive and receptive to the needs of others (Clark & Mills, 1979; Clark et al., 1987) and that others should be sensitive and

responsive to their needs. In times of stress, the fear that they will not receive support and/or additional burden of providing reciprocal support may dissuade women from seeking assistance. The belief their needs will be met by others may be a prerequisite for open disclosure among Euro-American women. Given that minorities cope with discrimination and prejudice on a daily basis, perhaps women of color come to realize that when others do not meet their needs, it is not an indicator of their personal worth or how much they deserve assistance. Rather, it may be a function of impersonal forces such as a lack of resources, competing demands, discrimination, etc. The belief that relationships should be balanced in this way may not be necessary for open disclosure among women of color. Thus, the sense of obligation associated with a communal orientation may keep Euro-Americans from seeking the support they need following victimization, thereby decreasing their Openness.

Among women in all three groups, four of the proposed components of Openness emerged as significant in the victimization-distress relationship. The final models showed a lack of self-disclosure resulting from self-silencing (Jack & Dill, 1992) and self-monitoring (Lenox & Wolfe, 1984; Wolfe et al., 1986; Snyder, 1979) diminished Openness across ethnicity. Similarly, more trust in partner (Larzelere & Huston, 1980) and a positive network orientation (Vaux et al., 1986) increased Openness. Perhaps women who do not trust their partners are unwilling to be open in other relationships. Women who lack trust in their partner may fear that their personal disclosure to others will get back to their abusive partners. Alternatively, abusive partners may have subtly or overtly undermined women's attitudes toward other relationships (Marshall, 1999).

Several differences also emerged between the three groups on Openness. Psychological abuse emerged as a negative indicator of Openness for African American and Euro-American women. This effect was stronger among African Americans than Euro-Americans. Generally, the more egalitarian nature of intimate relationships among these groups of women (de Leon, 1993; Harris, 1996; Myers, 1989; Reid & Bing, 2000; Roschelle, 1997) may increase the negative impact of both the subtle and overt forms of psychological abuse on their tendency to be open to interpersonal relationships. The submissive role often assumed by Mexican American women (Miller, 1978; Peñalosa, 1998) may allow them to compartmentalize their partners' psychological abuse in ways not readily available to women of African and European descent. Mexican Americans may interpret their partners' psychologically abusive behavior as attempts to keep them submissive. Contrarily, African American and Euro-American women are unable to assume that their partners have an ulterior motive for such verbalizations and may not be able to dismiss such comments. Thus, psychological abuse may have a more negative impact on Openness for African Americans and Euro-Americans because they are unable to dismiss such comments.

The pervasive impact of psychological abuse for both African and Euro-Americans deserves attention. For African Americans, psychological abuse contributed more strongly to Openness than to Victimization. The pattern was reversed for Euro-Americans with psychological abuse making its strongest contribution to Victimization, as expected. The dual contribution in these groups supports past research showing a strong and pervasive impact for subtle and overt psychological abuse (Marshall, 1999).

The interpersonal construct, Openness, eliminated the need for Coping in the models for African Americans and Euro-Americans. Although Openness decreases with sustained Victimization, it had the ability to directly decrease the severity of symptoms in these groups. Openness served as a mediator and functioned much the same as Coping has been found to function in the victimization-distress relationship (Arata, 1999; Arata & Burkhart, 1998; Bergen, 1995; Frazier & Burnett, 1994; Heron et al., 1997; Lempert, 1996; Neville & Heppner, 1999; Ornduff & Monahan, 1999; Rabin et al., 1999; Regehr et al., 1999; Scott-Gilba et al., 1995; Ullman, 1996; Valentiner et al., 1996). Apparently, African American and Euro-American women cope with Victimization by being open to relationships, engaging in self-disclosure, and refraining from self-silencing and self-monitoring.

Coping resources functioned as a mediator only for women of Mexican descent. However, only intrapersonal components remained in the model. Self-esteem loaded negatively, while private self-consciousness, or introspection, was a positive indicator. Although self-esteem and private self-consciousness could assist Mexican American women in coping with their victimization, the positive path from Coping to Psychological Symptoms makes an alternative explanation plausible. The positive path implies that as Coping increased, so did Psychological Symptoms, suggesting that these Coping resources should be considered ineffective. It may be that the introspection associated with private self-consciousness (Scheier & Carver, 1985a) takes the form of rumination about problems rather than problem solving when Mexican Americans are also low in self-esteem. Women with low self-esteem may tend to ruminate regarding their

victimization and assume they do not have the power to change their situation. This would explain the positive relationship between Coping and Psychological Symptoms among Mexican American women. Future research should compare the utilization of only interpersonal Coping resources to intrapersonal resources. The relative contribution of these types of resources to the psychological sequelae of interpersonal victimization could then be examined.

Interesting ethnic differences were evident in all constructs of the three models except Psychological Symptoms. As has been found in previous literature, the psychological impact of victimization is similar across different types of victimization (e.g., Banyard, 1997; Hampton, Jenkins, & Vandergriff-Avery, 1999; Milner & Crouch, 1999; Murphy & Cascardi, 1999; Riggs, Kilpatrick, & Resnick, 1992; Weisaeth & Eitinger, 1993). The findings of this study support the previous literature in suggesting that symptomology may be relatively independent of the specific act.

This study had several limitations. The age range was restricted to women 20 to 49 years old. This may have affected how some of the variables functioned. For example, family of origin violence was relatively recent for only a small proportion of the sample, the youngest women. A logical assumption may be that the psychological impact of sustaining violence in childhood would decrease with age. A second consequence of age is that many women likely had young children which would affect attempts to end a relationship with an abusive partner. For this reason and a general lack of financial resources, women such as those in this study may be more likely than others to stay with a man who victimized them. These factors may partially account for the importance of

current victimization over past assaults among Euro-Americans and Mexican Americans. African American communities have proportionately more single mothers (Murry & Brody, 1999) which likely leads to more acceptance or less ostracism when women choose to end a relationship. Consequently, the need to stay with an abusive man would not be as strong as it would be among Euro-American or Mexican Americans. This decreased pressure could be what allowed past victimization to be so important among African American women. In other groups, women's need to protect themselves and their children could increase the importance of current victimizations on their psychological state and minimize the impact of previous victimizations.

SES was also restricted. Consequently, there is no way to know whether these models would be replicated with women from other social classes. Thus, this limits the generalizability of these findings. Expanding the study to include individuals in higher socioeconomic strata across all three ethnic groups would be a useful endeavor.

One problem with this study was the inclusion of both interpersonal and intrapersonal indicators of Coping. The dual nature of the construct may have been even more problematic given the interpersonal nature of the Openness construct. The incorporation of both types of coping resources into one construct was due to the assumption that both were necessary for effective coping.

Another limitation was the elimination of two measures from all three models. Therapy was eliminated as a Coping resource from all models due to low associations with other variables. This may be explained two ways. First, the use of psychotherapy was a single item, asking the number of times women sought psychotherapy. Perhaps an

assessment of the reasons for therapy or the type of services (e.g., family, couples, group, individual) would be important for the Coping construct. Alternatively, perhaps women from low socioeconomic classes may not possess the financial or nonmonetary (e.g., available childcare or transportation) resources to use psychotherapy as a coping resource. This should be investigated in future research.

Trust in friends was eliminated as an indicator of Openness for all three groups. This finding appears to contradict previous research that open communication requires trust in others (Bierhoff, 1992; Drews & Bradley, 1989; Evans, 1978; Folkman et al., 1986; Heiberg et al., 1975; Kaufman & Wohl, 1992; Kelley et al., 1997; Lubell & Soong, 1982; Pennebaker, 1997; Sadavoy, 1997; Steel, 1991; Tyler, 1979). However, given the strong familial relationships found among families of African (APA, 1993; Hecht et al., 1993; Kochman, 1981; Ting-Toomey, 1986) and Mexican (APA, 1993; Marin & Marin, 1991) descent, and the notion that women of low SES, compared to those of higher SES, may have smaller social networks (Bassuk et al., 1996; Taylor et al., 1996) and/or social relationships of lesser quality (Belle, 1982b; Dohrenwend & Dohrenwend, 1970; Eckenrode, 1983; Fisher, 1982; Moody & Gray, 1972), this finding may be due to the specificity of the items. The question used the term friends as opposed to more broad nomenclature such as social and familial network. Thus, the measure may have been too narrow to adequately assess the trust women of low SES feel towards those upon whom they rely for social support.

By definition, Openness involved disclosure of personal information. However, specific disclosure of victimization was not assessed in this study, resulting in another

limitation. Future studies should examine the conditions under which women are likely to talk to others about their victimization. Addressing the responses received by women following their disclosures and the resulting impact on their psychological state and desire to be open in the future would also enhance understanding of when women talk about victimization and the consequences of such openness.

The arbitrary measure for past sexual assault created by multiplying number of incident by a severity weight resulted in another limitation to this study. In effect, use of a weapon was arbitrarily considered 5 times worse than having been touched or fondled. There is no reason to believe this type of relationship would hold. A more serious problem may be that context was not taken into account. Conceivably, being touched or fondled by a father twice at age 9 could have a much greater (and broader) psychological impact on an adult woman than having been raped by a stranger with a gun at age 19 and again at 22. There are three other problems with the measure. Sexual assaults by multiple perpetrators were assumed to be similar to the same number of assaults by one individual. Further, age at assault was not considered. Finally, the measure differed from all other measures of Victimization. Only for sexual assaults were women asked to report the actual number of times an act occurred. The other measures used response scales. Asking women to directly report the number of incidents of each type of assault may have resulted in inaccurate information due to underreporting or overreporting. Further studies should assess different typed of Victimization using similar types of measures.

Finally, several issues not addressed by this study should be included in future research. For example, a comparison of the effects of past and current victimization on

women's mental health and the use of coping resources would be helpful. It is possible that those with a history of past victimization have either dealt with their sustained aggression sufficiently to overcome the psychological symptoms associated with them or are unable to deal with these issues due to current stressors and victimizations. It is also important to have clear coping measures. Given the interpersonal nature of the Openness construct and its hypothesized function as a mediating variable, the Coping construct may not have been as distinct as it should have been. The emergence of Coping as a mediator for women of Mexican descent highlights its importance and emphasizes the need for future research to address this distinction.

The results of this study should be generalized only with caution. Honeycutt, Marshall, and Weston (2000) compared the sample to data from the 1990 Census and 1995 American Household Survey for this metropolitan area. They found the sample was generally representative of low-income women with a few exceptions (e.g., higher education, less likely to work) that would be expected from women volunteering for a longitudinal study.

However, the robustification procedures may have affected the results, thereby decreasing generalizability. By downweighting extreme scores to meet the statistical normality requirements, important findings may have been obscured. Robustification gives greater emphasis to scores closer to the mean, downweighting the effects of extremes. To analyze the means by which women decrease the psychological impact of victimization in a manner that is truly representative of the population, extreme scores must be considered because they accurately reflect the reality of some women. This study

compromised the competing requirements for normality and generalization by downweighting outlying scores on all indicators. This procedure allowed the inclusion of individuals reporting higher and lower levels of Victimization, Coping, Openness and Psychological Symptoms while decreasing the impact of their extreme scores.

The differences in the three models underscore the likelihood that different factors may play key roles in the victimization recovery process for women of African, European, and Mexican descent. Integration of this information into ethnically appropriate intervention strategies with low-income women who have been victimized could greatly improve the efficacy of assistance provided. In this context, it is important to note that similar interventions would be more likely to be effective for African Americans and Euro-Americans than for women of color from different ethnic backgrounds. This is because the pattern found in the model for Mexican Americans was quite different from the other two groups.

The importance of Openness to relationships was underscored by the results. The role of Openness in all three models suggests that the role of others is critical to women's recovery following victimization. Although open communication is the basis of psychotherapy and a prerequisite for effective interventions (e.g., Anderson et al., 1999; Brown, 1990; Keijsers et al., 2000; Stiles et al., 1998), only one previous study (David & Suls, 1999) addressed the efficacy of disclosure on dealing with stressful events. Thus, this research provided an empirical basis for interventions involving interpersonal relationships and honest communication with others. Consequently, interventions that assist women in learning to communicate openly with others in their social networks in a

manner that is congruent with their inner thoughts, feelings, and beliefs should be implemented. For example, instilling a belief in the efficacy of social networks can help women to adjust following victimization.

The results also showed that psychological abuse is an important type of victimization to be assessed. In addition, it directly affected Openness among African Americans and Euro-Americans. Consequently, interventions should address this type of victimization and its negative influence on women's relationships with others, even when isolation is not part of the content involved in the psychological abuse perpetrated by women's partners.

Finally, another factor important to the recovery process for Euro-Americans is their belief in the sensitivity of others to their needs and the importance they place on being sensitive to the needs of others. This tendency should be addressed during intervention through assisting women of European descent to identify their own needs and appropriate means of having these needs met while balancing women's desire to assist others.

Overall, the findings supported previous research showing that victimization results in psychological symptoms. The models also shows the association is not as direct as implied in the literature. This study underscored the notion that minorities are not homogenous groups in comparison to Euro-Americans. Research should further examine differences and similarities between African Americans and Mexican Americans, as well as other Hispanic subgroups and ethnic minorities. This study successfully expanded the literature by addressing how women cope with the psychological impact of interpersonal

victimization and examining the influence of interpersonal openness on this relationship among low-income, ethnically diverse women. It should be noted, however, that the failure to find consistent coping resources used by women to manage the effects of victimization contradicts past research. There is a great deal of information regarding the impact of openness on coping with traumatic experiences that should continue to be explored, especially in relation to its influence on the use of coping resources. Future studies should build on the present findings to continue to assess the use of openness in coping with trauma and to develop ethnically appropriate and effective interventions. These interventions will then need to be examined to determine whether or not they improve both coping with trauma and the mental and physical health outcomes of women who sustain interpersonal aggression.

Table 1
MANOVA Results by Ethnicity.

	African Americans			Euro-Americans			Mexican Americans		
	M	(SD)	Range	M	(SD)	Range	M	(SD)	Range
Victimization									
Past Partner Violence	1.27[a]	(1.27)	.00-5.00	1.67[ab]	(1.36)	.00-5.00	1.23[b]	(1.42)	.00-5.00
Family of Origin Violence	.92	(1.01)	.00-5.00	1.11	(1.10)	.00-4.27	.87	(1.13)	.00-4.82
Past Sexual Assault	16.78	(64.55)	.00-520	34.53	(83.71)	.00-495	30.29	(94.33)	0-752
Partner Violence (z-score)	.23	(2.75)	-1.37-16.41	-.05	(1.98)	-1.37-9.95	-.16	(2.22)	-1.37-16.55
Partner Sexual Aggression (z-score)	.44[ab]	(3.00)	-1.11-17.71	-.22[a]	(1.75)	-1.11-9.14	-.25[b]	(1.94)	-1.11-10.56
Partner Psychological Abuse	6.43	(5.68)	.00-26.04	6.72	(5.79)	.10-26.01	5.68	(5.51)	.00-22.01
Revictimization	.69[a]	(.46)	.00-6.00	.82[ab]	(.39)	.00-6.00	.65[b]	(.48)	.00-6.00
Coping									
Optimism	5.66[a]	(.75)	3.00-14.00	5.25[a]	(.62)	2.86-7.14	5.44[a]	(.95)	3.57-14.00
Self-Esteem	5.67[ab]	(1.12)	1.30-7.00	5.25[a]	(1.07)	1.50-7.00	5.32[b]	(1.16)	1.90-7.00
Private Self-Consciousness	4.86[ab]	(1.33)	1.00-7.00	4.27[a]	(1.25)	1.00-7.00	4.43[b]	(1.39)	1.00-7.00
Social Network	15.16	(22.83)	.00-200	14.95	(18.83)	.00-99	14.43	(36.93)	1.00-500
Therapy	.17[a]	(.38)	.00-99	.30[ab]	(.46)	1.00-150	.18[b]	(.38)	.00-36.00
Openness									
Self-Silencing	3.42	(1.01)	1.11-6.00	3.31	(.78)	1.22-6.00	3.44	(.92)	1.00-6.00
Communal Orientation	5.24	(.87)	2.83-7.00	5.35	(.70)	3.33-7.00	5.19	(.91)	2.17-7.00
Trust in Partner	4.90	(1.42)	1.00-7.00	4.93	(1.59)	1.00-7.00	5.13	(1.40)	1.13-7.00
Trust in Friends	3.42	(.80)	1.00-6.00	3.39	(.65)	1.00-5.29	3.37	(.79)	1.00-6.00
Self-Monitoring	4.45[a]	(1.31)	1.00-7.00	4.36[b]	(1.33)	1.14-7.00	3.99[ab]	(1.42)	1.00-7.00
Network Orientation	3.81[a]	(.72)	1.00-6.00	4.08[ab]	(.70)	1.59-5.53	3.89[b]	(.69)	2.00-5.82
Psychological Symptoms									
Global Distress	.84	(.78)	.00-3.63	.86	(.65)	.00-3.41	.89	(.75)	.00-3.54
Dissociation	.69	(.80)	.00-4.00	.72	(.68)	.00-3.64	.78	(.89)	.00-3.79
Suicidal Ideation	1.72	(1.13)	1.00-7.00	1.83	(1.10)	1.00-7.00	1.97	(1.33)	1.00-7.00

*Means sharing a superscript differ at $p<.05$.

Table 2
Correlation Matrix for Sample.

		Victimization							Coping					Openness						Psych.Sympt.		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Victimization																						
1	Past Partner	-																				
2	Family of Origin	.23**	-																			
3	Past Sex Assault	.18**	.27**	-																		
4	Partner Violence	.23**	.21**	.10**	-																	
5	Partner Sex	.14**	.22**	.18**	.57**	-																
6	Partner Psych.	.19**	.23**	.11**	.62**	.55**	-															
7	Revictimization	.52**	.56**	.31**	.55**	.55**	.55**	-														
Coping																						
8	Optimism	-.01	.01	.05	.05	.01	.08*	-.01	-													
9	Self-Esteem	-.11**	-.16**	-.14**	-.20**	-.18**	-.35**	-.26**	.00	-												
10	Priv. Self-Consc.	.08*	.03	-.02	.13**	.12**	.28**	.13**	.21**	-.10**	-											
11	Social Network	-.01	.03	-.02	-.07	-.05	-.05	-.02	.02	.10**	.05	-										
12	Therapy	.10**	.09*	.11**	-.03	.13**	.04	.17**	-.07*	-.08*	-.04	.07*	-									
Openness																						
13	Self-Silencing	.06	.05	.03	.13**	.15**	.22**	.09*	.21**	-.22**	.23**	-.01	-.03	-								
14	Communal Orient.	.04	.07*	.02	-.03	-.02	-.07*	.06	-.07*	.13**	.07*	.10**	.09*	-.04	-							
15	Trust in Partner	-.03	-.09**	-.04	-.30**	-.28**	-.54**	-.29**	-.03	.29**	-.07*	.05	-.03	-.10**	.04	-						
16	Trust in Friends	.02	.01	-.06	.01	-.05	.03	-.00	.31**	-.01	.13**	.10**	-.01	.08*	.01	-.02	-					
17	Self-Monitoring	.18**	.10**	.03	.17**	.17**	.24**	.21**	.25**	-.26**	.28**	-.03	.01	.24**	-.04	-.16**	.07*	-				
18	Network Orientation	-.06	.03	.02	-.16**	-.13**	-.20*	-.01	-.08*	.21**	-.13**	.05	.02	-.16**	.19**	.13**	.13**	-.17**	-			
Psychological Symptoms																						
19	Global Distress	.19**	.21**	.14**	.31**	.40**	.52**	.39**	.16**	-.59**	.26**	-.04	.10**	.23**	-.13**	-.30**	.05	.34**	-.21**	-		
20	Dissociation	.15**	.17**	.10**	.21**	.34**	.43**	.32**	.13**	-.49**	.24**	-.02	.07*	.17**	-.15**	-.22**	.04	.30**	-.16**	.91**	-	
21	Suicidal Ideation	.18**	.22**	.18**	.27**	.35**	.38**	.33**	.09*	-.59**	.15**	-.09*	.10**	.16**	-.11**	-.25**	.05	.25**	-.18**	.65**	.58**	-

* $p < .05$, ** $p < .01$

Table 3
Correlation Matrix for African Americans.

		Victimization							Coping					Openness						Psych.Sympt.		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Victimization																						
1	Past Partner	-																				
2	Family of Origin	.34**	-																			
3	Past Sex Assault	.10	.26**	-																		
4	Partner Violence	.32**	.29**	.23**	-																	
5	Partner Sex	.21**	.32**	.24**	.69**	-																
6	Partner Psych	.28**	.25**	.22**	.63**	.58**	-															
7	Revictimization	.56**	.58**	.32**	.63**	.63**	.59**	-														
Coping																						
8	Optimism	-.03	-.02	.04	.02	-.03	.06	-.03	-													
9	Self-Esteem	-.14*	-.15**	-.07	-.17**	-.22**	-.33**	-.23**	-.01	-												
10	Priv. Self-Consc.	.14*	.09	.09	.19**	.13*	.31**	.17**	.18**	-.11*	-											
11	Social Network	.01	.07	-.05	-.08	-.10	-.06	-.05	.01	.07	-.07	-										
12	Therapy	.03	.10	-.02	-.01	.25**	.11*	.19**	-.07	-.10	.00	-.04	-									
Openness																						
13	Self-Silencing	.07	.09	.11*	.13*	.15**	.23**	.10	.22**	-.20**	.20**	-.06	-.07	-								
14	Communal Orient.	.07	.10	.06	-.03	-.01	-.01	.06	-.12*	.14*	.09	.00	.07	-.10	-							
15	Trust in Partner	-.04	-.10	-.08	-.22**	-.25**	-.43**	-.26**	-.06	.23**	.03	.12*	-.07	-.11*	.10	-						
16	Trust in Friends	.03	.07	-.06	-.05	-.10	.04	.02	.24**	-.05	.15**	.08	.02	.03	-.04	-.08	-					
17	Self-Monitoring	.19**	.21**	.13*	.23**	.21**	.28**	.24**	.23**	-.24**	.31**	-.05	-.01	.33**	.00	-.16**	.10	-				
18	Network Orientation	-.03	.04	-.05	-.14**	-.11*	-.13*	.00	.01	.21**	-.11	.04	-.10	-.17**	.08	-.02	.13*	-.18**	-			
Psychological Symptoms																						
19	Global Distress	.22**	.25**	.22**	.32**	.44**	.55**	.43**	.07	-.58**	.20**	-.07	.14*	.22**	-.07	-.25**	.07	.36**	-.14*	-		
20	Dissociation	.19**	.19**	.13*	.22**	.34**	.45**	.33**	.04	-.48**	.18**	-.04	.10	.15*	-.09	-.18**	.08	.29**	-.06	.91**	-	
21	Suicidal Ideation	.25**	.38**	.24**	.33**	.45**	.42**	.39**	.06	-.52**	.14*	-.12*	.15*	.19**	-.04	-.14*	.04	.27**	-.11*	.63**	.55**	-

* $p < .05$, ** $p < .01$

Table 4
Correlation Matrix for Euro-Americans.

		Victimization							Coping					Openness						Psych.Sympt		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Victimization																						
1	Past Partner	-																				
2	Family of Origin	.10	-																			
3	Past Sex Assault	.26**	.17*	-																		
4	Partner Violence	.14*	.12	.06	-																	
5	Partner Sex	.14*	.19**	.30**	.42**	-																
6	Partner Psych.	.10	.21**	.10	.61**	.58**	-															
7	Revictimization	.47**	.54**	.34**	.49**	.54**	.52**	-														
Coping																						
8	Optimism	.13	.06	.08	.15*	-.02	.22**	.13*	-													
9	Self-Esteem	-.04*	-.12	-.21**	-.26**	-.16*	-.40**	-.29**	-.03	-												
10	Priv. Self-Consc.	.04	-.01	-.09	.05	.01	.24**	.02	.17*	-.11	-											
11	Social Network	-.10	.15	.05	-.14*	-.06	-.08	-.01	.01	.11	.02	-										
12	Therapy	.12	.07	.15	-.09	.00	-.06	.12*	-.02	-.10	-.09	.27**	-									
Openness																						
13	Self-Silencing	.00	.04	.07	.14*	.13*	.28**	.13*	.18**	-.34**	.23**	-.00	.04	-								
14	Communal Orient.	-.06	.04	-.10	-.10	-.18**	-.14*	-.11	-.15*	.10	.07	.07	.09	-.01	-							
15	Trust in Partner	-.04	-.21**	-.14*	-.42**	-.37**	-.64**	-.39**	-.05	.38**	-.08	.09	.01	-.11	-.04	-						
16	Trust in Friends	-.09	-.06	-.08	-.01	-.17**	.09	-.07	.23**	-.07	-.09**	.11	-.02	-.01	.09	-.01	-					
17	Self-Monitoring	.19**	-.03	-.04	.08	.01**	.23**	.09	.26**	-.33**	.31**	-.01	-.04	.18**	-.10	-.20**	.04	-				
18	Network Orientation	-.09	.03	.01	-.17**	-.18**	-.21**	-.04	-.18**	.20**	-.05	.23**	.04	-.11	.20**	.21	.21**	-.20**	-			
Psychological Symptoms																						
19	Global Distress	.19**	.15*	.22**	.37**	.44**	.55**	.43**	.33**	-.52**	.22**	-.05	.13*	.27**	-.15*	-.38**	-.08	.32**	-.16*	-		
20	Dissociation	.16*	.10	.23**	.31**	.46**	.49**	.38**	.33**	-.34**	.22**	-.04	.10	.22*	-.16*	-.26**	-.08	.26**	-.13*	.89**	-	
21	Suicidal Ideation	.16*	.17*	.27**	.27**	.27**	.44**	.37**	.11	-.58**	.12*	-.05	.15*	.15*	-.20**	-.42**	-.03	.17**	-.21**	.57**	.42**	-

* $p < .05$, ** $p < .01$

Table 5
Correlation Matrix for Mexican-Americans.

		Victimization							Coping					Openness						Psych.Sympt		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Victimization																						
1	Past Partner	-																				
2	Family of Origin	.20**	-																			
3	Past Sex Assault	.18**	.35**	-																		
4	Partner Violence	20**	.18**	.03	-																	
5	Partner Sex	.06	.13*	.09	.41**	-																
6	Partner Psych.	.15*	.20**	.04	.63**	.53**	-															
7	Revictimization	.49**	.53**	.31**	.48**	.46**	.53**	-														
Coping																						
8	Optimism	.00	.06	.09	.02	.02	.05	.01	-													
9	Self-Esteem	-.10	-.20**	-.11	-.26**	-.26**	-.36**	-.28**	-.07	-												
10	Priv. Self-Consc.	.11	.02	-.01	.08	.15*	.29**	.22**	.20**	-.20**	-											
11	Social Network	.01	-.06	-.03	-.04*	.01	-.04	.00	.03	.13*	.15*	-										
12	Therapy	.13*	.10	.23**	.09	.28**	.16*	.23**	-.10	.04	.07	-.01	-									
Openness																						
13	Self-Silencing	.12*	.02	-.07	.11 *	.15*	.18**	.09	.22**	-.19**	.27**	.02	-.09	-								
14	Communal Orient.	.04	.06	.07	.01	.08	-.10	.16*	.03	.17**	.07	.18**	.15*	.04	-							
15	Trust in Partner	-.00	.04	.08	-.32**	-.29**	-.57**	-.22**	.01	.32**	-.17**	-.01	-.03	-.10	.05	-						
16	Trust in Friends	-.09	-.00	-.05	.09	-.11	.11	.02	.46**	-.02	.24**	.12*	-.06	-.23**	.03	-.02	-					
17	Self-Monitoring	.16*	.09	.02	.13	.18**	.18**	.24**	.27**	-.28**	.21**	-.02	.14*	.19**	-.07	-.10	.11	-				
18	Network Orientation	-.13*	-.02	.05	-.17**	-.09	-.30**	-.09	-.05	.30**	-.16*	-.30	.08	-.16*	.30**	.24**	.06	-.15*	-			
Psychological Symptoms																						
19	Global Distress	.15*	.22**	.02	.27**	.34**	.48**	.36**	.20**	-.67**	.38**	-.00	-.00	.23**	-.20**	-.31**	.11	.36**	-.36**	-		
20	Dissociation	.10	.20**	-.00	.15*	.32**	.37**	.29**	.13*	-.61**	.35**	.00	.02	.16*	-.21**	-.25**	.07	.36**	-.30**	.93**	-	
21	Suicidal Ideation	.15*	.13*	.08	.24**	.34**	.32**	.30**	.13*	-.66**	.23**	-.09	-.01	.13*	-.11	-.25**	.10	.32**	-.25**	.75**	.69**	-

* $p < .05$, ** $p < .01$

Table 6
Correlation Matrix for African-Americans (Robust).

		Victimization							Coping					Openness						Psych.Sympt		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Victimization																						
1	Past Partner	-																				
2	Family of Origin	.33**	-																			
3	Past Sex Assault	.09	.26**	-																		
4	Partner Violence	.32**	.29**	.23**	-																	
5	Partner Sex	.21**	.32**	.24**	.69**	-																
6	Partner Psych.	.27**	.25**	.22**	.63**	.58**	-															
7	Revictimization	.56**	.58**	.32**	.63**	.63**	.59**	-														
Coping																						
8	Optimism	-.03	-.02	.04	.02	.03	.06	-.03	-													
9	Self-Esteem	-.13*	-.15**	-.07	-.17**	-.22**	-.33**	-.23**	-.01	-												
10	Priv. Self-Consc.	.14*	.09	.09	.19**	.13*	.31**	.17**	.18**	-.11*	-											
11	Social Network	.00	.07	-.05	-.08	-.10	-.06	-.05	.00	.07	-.07	-										
12	Therapy	.03	.10	-.02	-.01	.25**	.11*	.18**	-.07	-.10	-.00	-.04	-									
Openness																						
13	Self-Silencing	.07	.09	.11*	.13*	.15**	.23**	.10	.22**	-.20**	.20**	-.06	-.07	-								
14	Communal Orient.	.07	.10	.06	-.03	-.01	-.01	.06	-.12*	.14*	.09	.00	.07*	-.10	-							
15	Trust in Partner	-.04	-.10	-.07	-.22**	-.24**	-.43**	-.26**	-.05	.23**	.03	.12*	-.07	-.11*	.10	-						
16	Trust in Friends	.03	.07	-.06	-.05	-.10	.04	-.02	.17**	-.05	.15**	.07	-.01	.03*	.04	-.08	-					
17	Self-Monitoring	.18**	.21**	.13	.23**	.21**	.28**	.24**	.16**	-.24**	.30**	-.05	.01	.32**	.00	-.16**	.10	-				
18	Network Orientation	-.03	.04	-.05	-.14**	-.11*	-.13*	.01	-.01	.21**	-.11**	-.04	.11*	-.17**	.08	.02	.13*	-.17**	-			
Psychological Symptoms																						
19	Global Distress	.21**	.25**	.22**	.32**	.44**	.55**	.43**	.05	-.58**	.20**	-.07	.15*	.22**	-.08	-.25**	.07	.36**	-.13*	-		
20	Dissociation	.19**	.19**	.13*	.22**	.34**	.45**	.33**	.02	-.48**	.19**	-.04	.11*	.14*	-.09	-.18**	.08	.29**	-.06	.91**	-	
21	Suicidal Ideation	.25**	.37**	.24**	.33**	.45**	.42**	.39**	.05	-.50**	.14*	-.12*	.15**	.20**	-.04	-.14*	.04	.26**	-.12*	.62**	.55**	-

* $p < .05$, ** $p < .01$

Table 7
Correlation Matrix for Euro-Americans (Robust).

		Victimization						Coping					Openness				Psych.Sympt					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Victimization																						
1	Past Partner	-																				
2	Family of Origin	.10	-																			
3	Past Sex Assault	.26**	.17*	-																		
4	Partner Violence	.14*	.12	.06	-																	
5	Partner Sex	.14*	.19**	.30**	.42**	-																
6	Partner Psych.	.10	.21**	.10	.61**	.58**	-															
7	Revictimization	.47**	.54**	.34**	.49**	.54**	.52**	-														
Coping																						
8	Optimism	.13	.06	.08	.15*	-.02	.22**	.13*	-													
9	Self-Esteem	-.04	-.12	-.21**	-.26**	-.16*	-.40**	-.29**	-.03	-												
10	Priv. Self-Consc.	.04	-.01	-.09	.05	.01	.24**	.02	.17*	-.11	-											
11	Social Network	-.10	.15	.05	-.14*	-.06	-.08	-.01	.01	.11	.02	-										
12	Therapy	.12	.07	.15	-.09	.01	-.06	.12*	-.02	-.10	-.09	.27**	-									
Openness																						
13	Self-Silencing	.00	.04	.07	.14*	.13*	.28**	.13*	.18**	-.34**	.23**	-.00	.04	-								
14	Communal Orient.	-.06	.04	-.10	-.10	-.18**	-.14*	-.11	-.15*	.10	.07	.07	.09	-.01	-							
15	Trust in Partner	-.04	-.21**	-.14*	-.42**	-.37**	-.64**	-.38**	-.05	.38**	-.08	.09	.01	-.11	-.04	-						
16	Trust in Friends	-.09	-.06	-.08	-.01	-.17**	.09	-.07	.23**	-.07	-.09**	.11	-.02	-.01	.09	-.01	-					
17	Self-Monitoring	.19**	-.03	-.04	.08	.01**	.23**	.09	.26**	-.33**	.31**	.01	-.04	.18**	-.10	-.19**	.04	-				
18	Network Orientation	-.09	.03	.01	-.17**	-.18**	-.21**	-.04	-.18**	.20**	-.05	.23**	.04	-.11	.20**	.21	.21**	-.20**	-			
Psychological Symptoms																						
19	Global Distress	.19**	.15*	.22**	.37**	.44**	.54**	.43**	.33**	-.52**	.22**	-.05	.13*	.27**	-.15*	-.38**	-.08	.32**	-.16*	-		
20	Dissociation	.16*	.10	.23**	.31**	.46**	.49**	.38**	.33**	-.34**	.22**	-.04	.10	.22*	-.16*	-.26**	-.08	.26**	-.13*	.89**	-	
21	Suicidal Ideation	.16*	.17*	.27**	.27**	.27**	.44**	.37**	.11	-.58**	.12*	-.05	.15*	.15*	-.20**	-.42**	-.03	.17**	-.21**	.57**	.42**	-

* $p < .05$, ** $p < .01$

Table 8
Correlation Matrix for Mexican-Americans (Robust).

		Victimization							Coping					Openness						Psych.Sympt		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Victimization																						
1	Past Partner	-																				
2	Family of Origin	.20**	-																			
3	Past Sex Assault	.18**	.35**	-																		
4	Partner Violence	.20**	.18**	.03	-																	
5	Partner Sex	.06	.13*	.09	.41**	-																
6	Partner Psych.	.15*	.20**	.04	.63**	.53**	-															
7	Revictimization	.48**	.53**	.31**	.48**	.46**	.52**	-														
Coping																						
8	Optimism	.00	.06	.09	.02	.02	.05	.01	-													
9	Self-Esteem	-.10	-.19**	-.11	-.26**	-.26**	-.36**	-.28**	-.05	-												
10	Priv. Self-Consc.	.11	.02	-.01	.08	.15*	.29**	.22**	.20**	-.20**	-											
11	Social Network	.01	-.06	-.03	.04	.01	-.04	.00	.03	.13*	.15*	-										
12	Therapy	.13*	.10	.23**	.09	.28**	.16*	.23**	-.07	.04	.07	-.01	-									
Openness																						
13	Self-Silencing	.12*	.02	-.07	.11*	.15*	.18**	.09	.22**	-.19**	.27**	.02	-.09	-								
14	Communal Orient.	.04	.06	.07	.01	.08	-.10	.16*	.03	.17**	.07	.18**	.15*	.04	-							
15	Trust in Partner	-.01	.04	.08	-.32**	-.29**	-.57**	-.22**	.01	.32**	-.17**	-.01	-.03	-.10	.05	-						
16	Trust in Friends	-.08	-.00	-.05	.09	-.11	.11	.02	.46**	-.02	.24**	.12*	-.06	-.23**	.03	-.02	-					
17	Self-Monitoring	.16*	.09	.02	.13*	.18**	.18**	.24**	.27**	-.28**	.21**	-.02	.14*	.19**	-.07	-.10	.11	-				
18	Network Orientation	-.13*	-.02	.05	-.17**	-.09	-.30**	-.09	-.05	.30**	-.16*	-.03	.08	-.16*	.30**	.24**	.06	-.15*	-			
Psychological Symptoms																						
19	Global Distress	.15*	.21**	.02	.27**	.34**	.48**	.36**	.15*	-.67**	.38**	-.00	-.00	.23**	-.19**	-.31**	.10	.36**	-.36**	-		
20	Dissociation	.10	.19**	-.00	.15*	.32**	.37**	.29**	.10	-.61**	.35**	.00	.02	.16*	-.20**	-.24**	.07	.36**	-.30**	.93**	-	
21	Suicidal Ideation	.15*	.13*	.08	.24**	.34**	.32**	.30**	.10	-.66**	.23**	-.09	-.01	.13*	-.11	-.25**	.10	.32**	-.25**	.75**	.69**	-

* $p < .05$, ** $p < .01$

Table 9
Goodness-of-Fit Indices for the Final Structural Models for African Americans.

		Measurement Model				Structured Model
	Convention for Acceptable Fit	Victimization	Coping	Openness	Psychological Symptoms	Final Utilization Model
Chi-Square Value		13.28	.08	4.35	0	64.57
Degrees of Freedom		10	1	4	0	62
Associated p value	> .05	.23	.78	.37		.38
Chi-Square/df	< 3	1.33	.08	1.09	0	1.04
Comparative Fit Index (CFI)	> .90	.99	1.00	.99	1.00	.99
Goodness-of-fit Index (GFI)	> .90	.99	1.00	.99	-	.96
Adjusted Goodness of fit Index (AGFI)	> .90	.96	1.00	.97	-	.94
Root Mean Square Residual (RMSR)	small	1.31	.07	.03	-	.93
Standardized Root Mean Square Residual (SRMR)	< .05	.03	.01	.03	-	.05

Table 10
Goodness-of-Fit Indices for the Final Structural Models for Euro-Americans.

		Measurement Model				Structured Model
	Convention for Acceptable Fit	Victimization	Coping	Openness	Psychological Symptoms	Final Utilization Model
Chi-Square Value		1.30	.77	10.35	0	42.13
Degrees of Freedom		1	2	8	0	40
Associated p value	> .05	.25	.68	.23		.27
Chi-Square/df	< 3	1.30	.39	1.29	0	1.05
Comparative Fit Index (CFI)	> .90	.99	1.00	.93	1.00	.99
Goodness-of-fit Index (GFI)	> .90	.99	.99	.98	-	.96
Adjusted Goodness of fit Index (AGFI)	> .90	.97	.99	.95	-	.93
Root Mean Square Residual (RMSR)	small	.07	.24	.04	-	.08
Standardized Root Mean Square Residual (SRMR)	< .05	.02	.02	.05	-	.04

Table 11
Goodness-of-Fit Indices for the Final Structural Models for Mexican Americans.

		Measurement Model				Structured Model
	Convention for Acceptable Fit	Victimization	Coping	Openness	Psychological Symptoms	Final Utilization Model
Chi-Square Value		.81	.03	6.98	0	61.46
Degrees of Freedom		3	1	5	0	55
Associated p value	> .05	.85	.85	.19		.27
Chi-Square/df	< 3	.27	.03	1.40	0	1.12
Comparative Fit Index (CFI)	> .90	1.00	1.00	.94	1.00	.99
Goodness-of-fit Index (GFI)	> .90	.99	1.00	.99	-	.96
Adjusted Goodness of fit Index (AGFI)	> .90	.99	.99	.96	-	.93
Root Mean Square Residual (RMSR)	small	.02	.04	.04	-	.08
Standardized Root Mean Square Residual (SRMR)	< .05	.01	.00	.05	-	.04

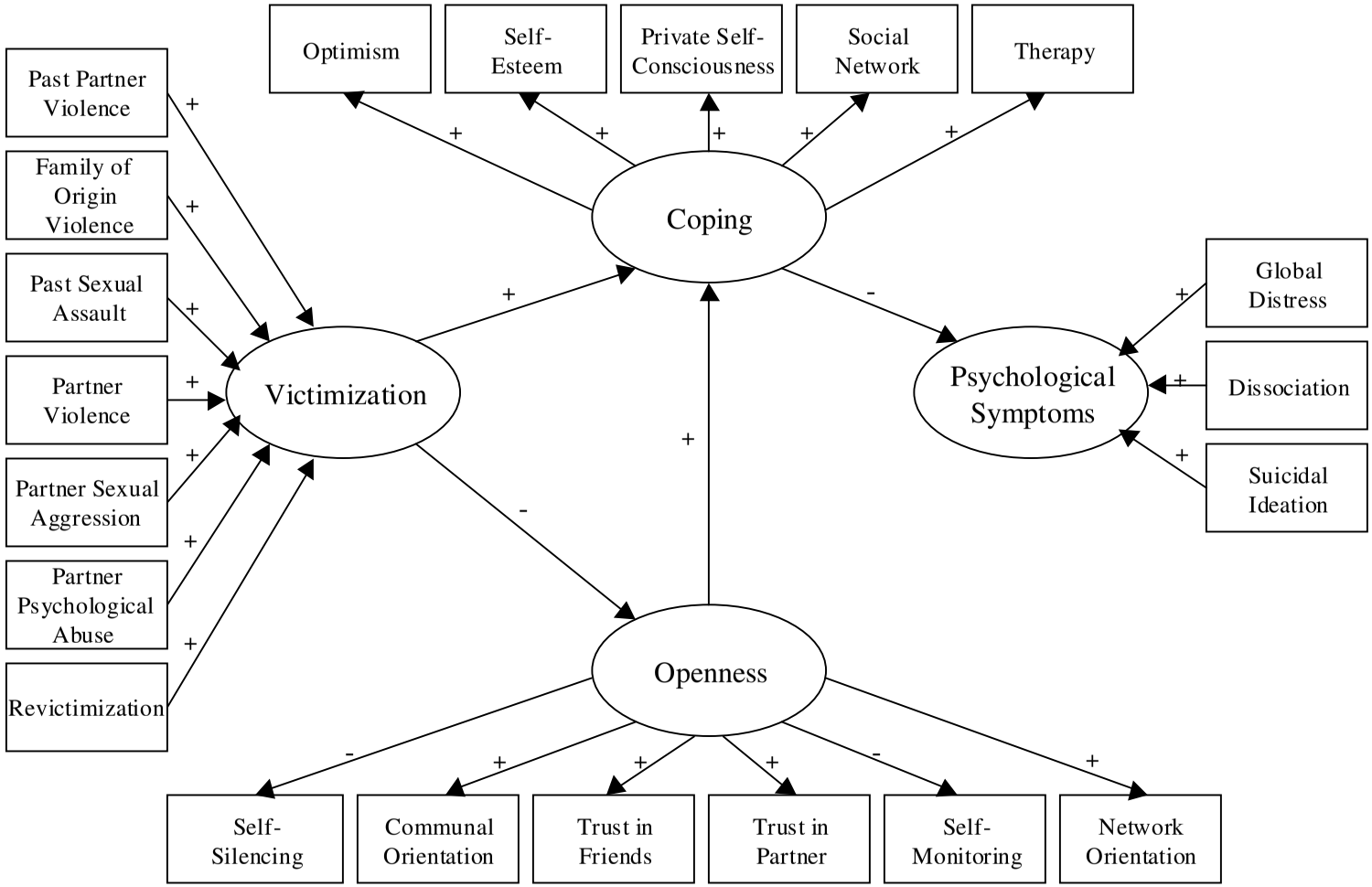

Figure 1. Proposed Full Causal Model.

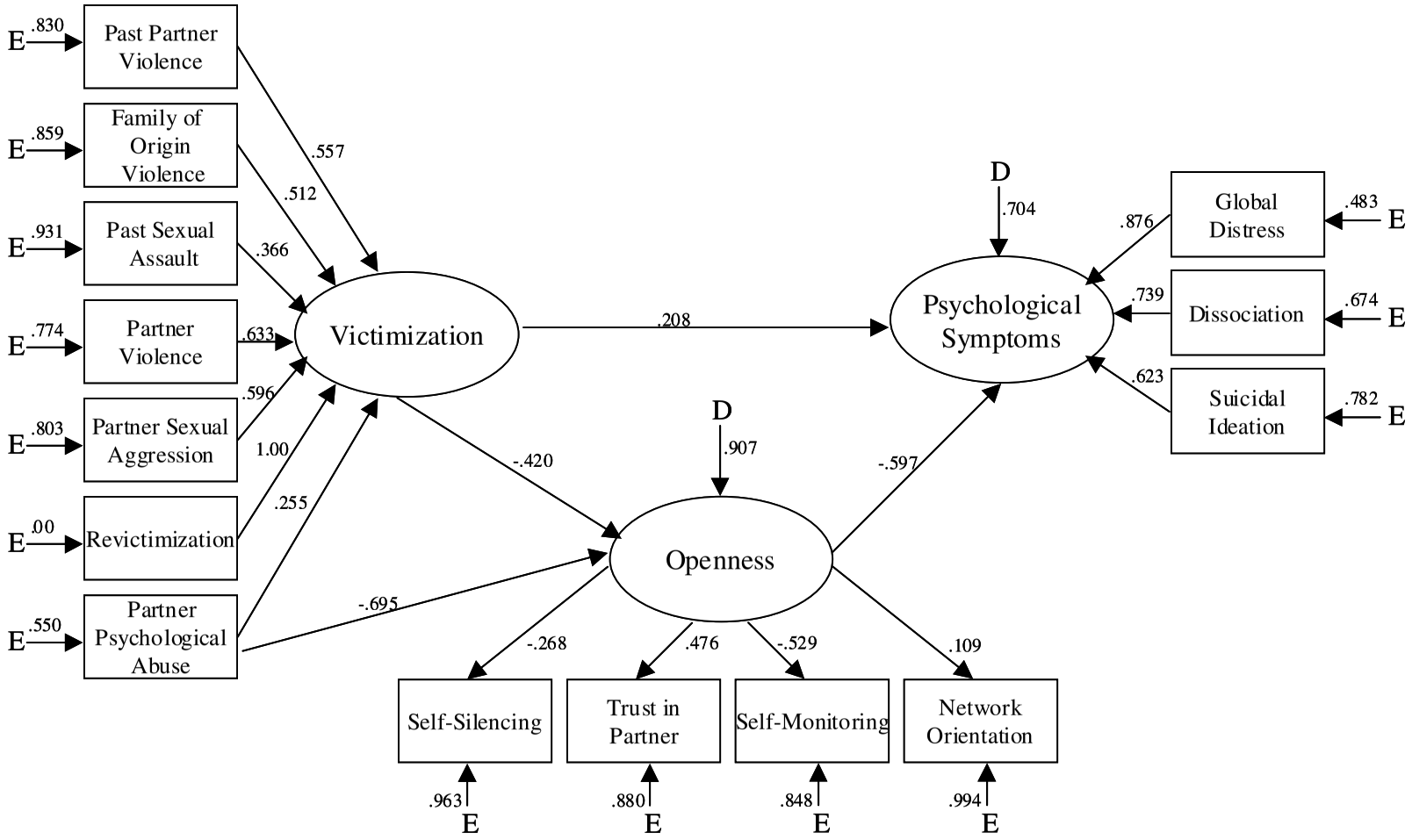

Figure 2. Final Causal Model for African Americans.

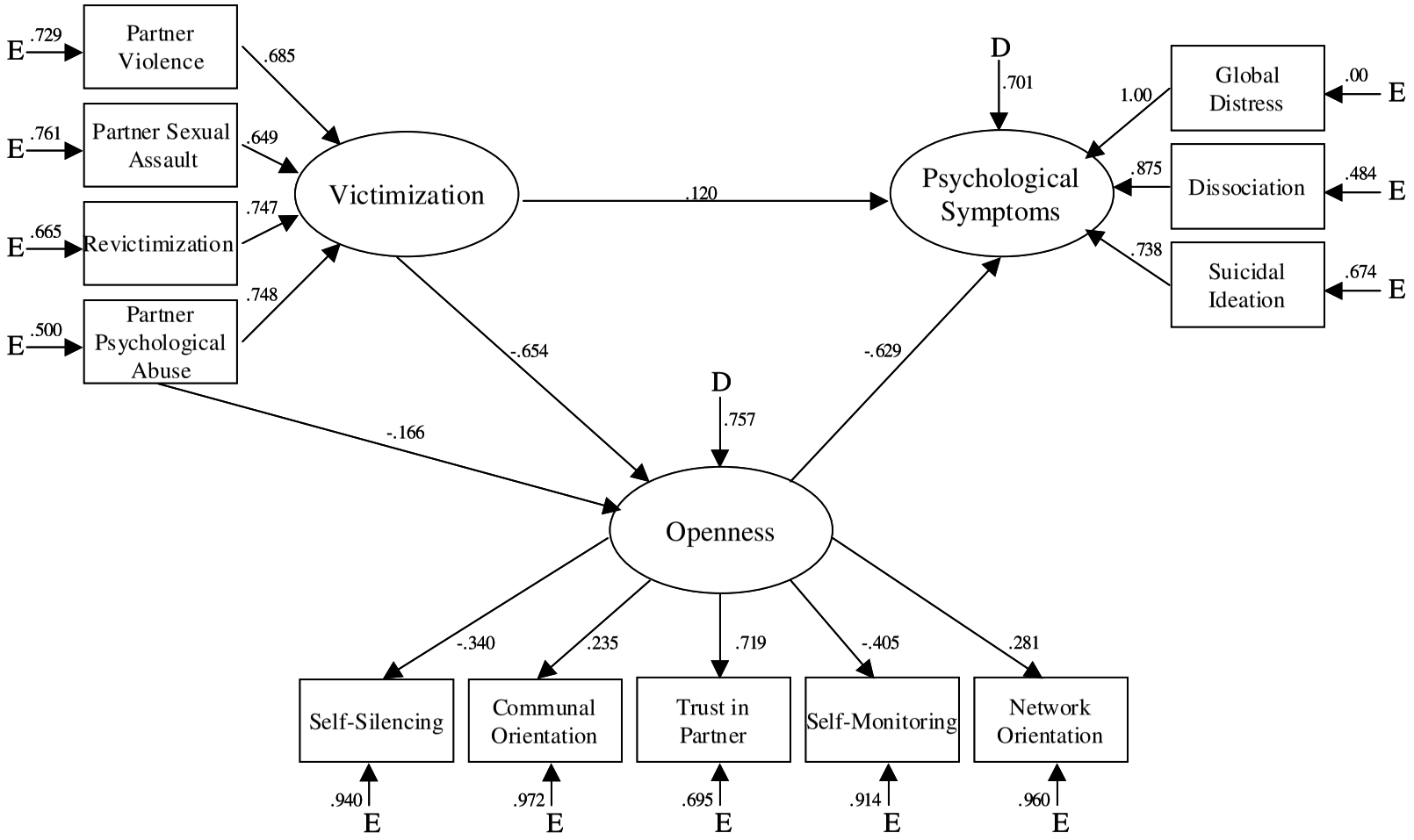

Figure 3. Final Causal Model for Euro-Americans.

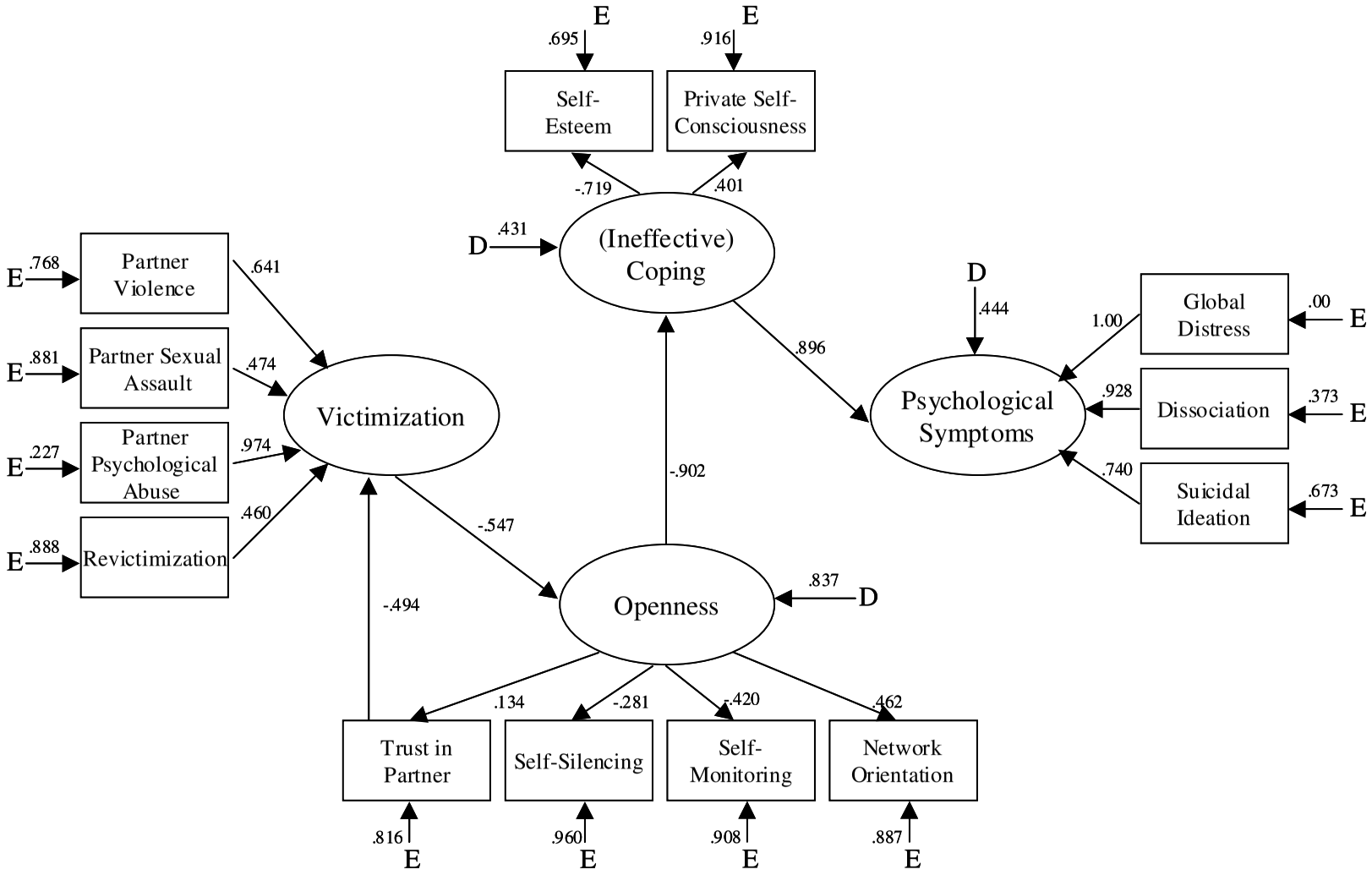

Figure 4. Final Causal Model for Mexican Americans.

APPENDIX A

RECRUITMENT LETTER

RECRUITMENT LETTER

Fall, 1995

To Women in the Southwest Area of Dallas County

My name is Linda Marshall. I am writing this letter to tell you about an important project in your area. I planned Project HOW, **H**ealth **O**utcomes of **W**omen, for many reasons. We know that women without much money are more likely to have some diseases (like diabetes) and more likely to die of other diseases (like breast cancer or high blood pressure) than women with more money. There are also differences in health care and rates of specific problems and illnesses depending on whether women are African American, Mexican American, or white but very little specific information is known. Unless more is learned, we can't make changes in health education and care that would help women of different ethnic backgrounds who don't have much money.

This project is dedicated to finding out HOW to help improve women's physical and mental health. Too often "experts" decide what we think and what is good for us or bad for us. Project HOW is different. We want to interview you to find out what you think and what your life is like. In return, we give gifts to women who participate. The more women we talk to, the better our information will be.

We need women who are willing to be interviewed once every 6 to 8 months about where they go for help, their background, beliefs, feelings, neighborhood, relationships, stress, health and health care. All of these things are related to health and well-being and we need information from your point of view. We want you to feel comfortable talking with us so our office staff will explain the many ways we protect each woman's privacy. Everyone with Project HOW is here because we want to help. Unfortunately, we are not able to provide counseling or services.

If you decide to participate, I will need you to come 4 times over 18 months and answer our questions honestly and openly for about 3 hours each time. In return, we will give you more valuable gifts for each interview. You will get $26 in cash and goods for Interview 1 and $37 or more for Interview 2 next spring. We will give you more than that for each of the last 2 interviews. I will send summaries of what we learn during and after the study and will use the combined results from all women to try to help women here and elsewhere.

We do interviews at 9, noon, 3, and 6 Sundays through Thursdays and at 9, noon, and 3 on Fridays and Saturdays. Sometimes different times can be arranged. Our offices are very near bus stops. Ora McQueen at the Mountain Lake office (467-8098) and Vernette Moss at the Zang office (943-3223) are our office managers. They and other staff members would like to talk to you about participating in Project HOW.

Please call or come by soon to see if you can join Project HOW. Please be patient with us because a lot of women are calling and our office staff wants to talk to each of you. Your participation is important to us. We will continue accepting new participants until we have completed this first set of interviews.

Thank you very much,

Dr. Linda L. Marshall
Director, Project HOW

APPENDIX B

PUBLIC SERVICE ANNOUNCEMENTS

PUBLIC SERVICE ANNOUNCEMENTS

English: (30 Seconds)

"You can make a difference in the health and welfare of future generations by participating in a local study called Project HOW: Health Outcomes of Women. Dr. Linda Marshall of the University of North Texas designed the study to learn how to improve the health of low income women. If you are a woman who lives in southwest Dallas County, are between the ages of 20 and 47, are in a long term dating relationship, and have a household income below or near the poverty level, you are eligible to participate. Volunteers will receive cash and gifts for completing interviews over a two years period. Interested women should call 467-8089 or 943-3223."

English: (15 Seconds)

"You can make a difference in the health and welfare of future generations by participating in a local study called Project How: Health Outcomes of Women. Women who live in southwest, Dallas County, and who meet other qualification criteria will receive cash and gifts for completing interviews over a two-year period. Call 943-3223 for information."

Spanish: (30 Seconds)

"Usted puede hacer la diferencia en la salud y bienestar de futuras generaciones al participar en un proyecto de salud llamado HOW: Health Outcomes of Women. La Dra. Linda Marshall de la Universidad de el Norte de Texas quiere saber como mejorar la

salud de mujeres de escasos recursos. Si used es una mujer que vive en el suroeste de el condado de Dallas, tiene entre los 20 y 47 anos, se encuentra en una relacion amorosa duradera, y sus recursos economicos son bajos o cercanos al nivel de pobreza, usted puede participar. Vlountarias recibiran dinero en efectivo y regalos al completar cada entrevista por un periodo de 2 anos. Interesadas llamar al 467-8098 o 943-3223."

Spanish: (15 Seconds)

"Usted puede hacer la diferencia en la salud y bienestar de futuras generaciones al participar en un proyecto de salud llamado HOW: Health Outcomes of Women. Mujeres que vivan en el suroeste de el condado de Dallas, y que llenen otros requisitos recibiran dinero en efetivo y regalos al completar cada entrevista por un periodo de 2 anos. Llama al 943-3223 para mas informacion."

`

APPENDIX C

CONTACT FORM USED IN RECRUITING

CONTACT FORM USED IN RECRUITING

Project H.O.W. - Recruitment and Contacts: Time 1

Initial contact by _____ Date_____

Type of contact: in person____ called office____ referred to her____
other____(explain)

How she learned about project_____

Qualifications:
(circle): African American Mexican Immigrant
Mexican American (US born) White American

Does she consider herself to have a low income (circle) no yes

If Mexican Immigrant, how long has she been in the U.S._____
(at least 10 years)

Age_____ (19 [in 1994] to 49 [during 1995])

How long she's been in a serious, long term relationship with a man
_____ (1+ yrs)

Information needed to schedule interview (print):

Participant name: _____
Phone: _____
Address: _____
City, State, Zip: _____

Times available for interviews: (3 hours for forms & interview)
Mondays_____
Tuesdays_____
Wednesdays_____
Thursdays_____
Fridays_____
Saturdays_____
Sundays_____

Office: ____ 1 = West Oak Cliff, 2 = East Oak Cliff, 3 = East Dallas

`

Contacts (notes on back):

Date	Method (phone, home, office, left note)	Result (scheduled, left message)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Day, Date, Time Scheduled & Rescheduled /Day, Date, Time of Interview

1._____
2_____
3._____
4._____

APPENDIX D
POVERTY FIGURES

1995 AND 1996 POVERTY FIGURES

BASED ON THE NUMBER OF PEOPLE IN THE HOUSEHOLD

1995 Poverty Figures

#	Yearly Poverty	Yearly 150%	Yearly 175%	Monthly Poverty	Monthly 150%	Monthly 175%
1	7,470	11,205	13,072	623	934	1,090
2	10,030	15,045	18,030	836	1,254	1,463
3	12,590	18,885	22,033	1,049	1,574	1,836
4	15,150	22,725	26,513	1,263	1,894	2,210
5	17,710	26,565	30,993	1,476	2,214	2,583
6	20,270	30,405	35,473	1,689	2,534	2,956
7	22,830	34,245	39,953	1,903	2,854	3,330
8	25,390	38,085	44,433	2,116	3,174	3,703

#	Yearly 200%	Monthly 200%
1	14,940	1,246
2	20,060	1,672
3	25,180	2,098
4	30,300	2,526
5	35,420	2,952
6	40,540	3,378
7	45,660	3,806
8	50,780	4,232

1996 Poverty Figures

#	Yearly Poverty	Yearly 150%	Yearly 175%	Monthly Poverty	Monthly 150%	Monthly 175%
1	7,740	11,610	13,545	645	968	1,129
2	10,360	15,540	18,130	863	1,295	1,511
3	12,980	19,470	22,715	1,082	1,623	1,893
4	15,600	23,400	27,300	1,300	1,950	2,275
5	18,220	27,330	31,885	1,518	2,278	2,657
6	20,840	31,260	36,470	1,737	2,605	3,039
7	23,460	35,190	41,055	1,955	2,933	3,421
8	26,080	39,120	45,640	2,173	3,260	3,803

#	Yearly 200%	Monthly 200%
1	15,480	1,290
2	20,720	1,727
3	25,960	2,163
4	31,200	2,600
5	36,440	3,037
6	41,680	3,473
7	46,920	3,910
8	52,160	4,347

`

APPENDIX E

PROJECT H.O. W. MASTER FORM

PROJECT H.O. W. MASTER FORM

This is the only form which would allow your identity to be matched with answers you give in the interviews. The office worker who administers this form will never know any of your answers to interview questions. Ms. Deirdre Harris, the interview co-ordinator, will give this form to Ms. Anne C. Freeman at the Dallas County Health Department for safe-keeping. Ms Freeman will not see any completed interviews. Dr. Linda L. Marshall at the University of North Texas will keep completed interviews. Dr. Marshall will not see this form unless funding for a follow-up study is obtained several years from now.

Completion of this form and your signature at the bottom shows that you received a copy of the Informed Consent Form signed by Ms. Anne C. Freeman and Dr. Linda L. Marshall.

Please print the information requested.

Date: _____

Full Name:

_____

first middle last

Current address:

_____

_____

Telephone number: _____

Social Security Number:_____

Driver License Number:_____

Texas Identification Number:_____

The following information will be used as your code on the interview forms. We will assign you a number so interviews can be connected without ever using names. This allows the researchers to identify changes in each woman's health and life situation so results can be used to find ways to help women become healthier.

Your first name or nickname used for interviews:

_____

`

Your Birthdate: _____

Where you were born:_____

Race/ethnicity (circle): African American
Mexican American White American

Mother's First Name: _____

Number of Brothers and Sisters:_____

Name of Mother's First(oldest)Child:_____

Your Partner's Initials: _____

Your Partner's race/ethnicity (circle): African American Mexican American
White American Other

Your partner's Birthdate: _____

The information I provide is true to the best of my knowledge.

_____
signature

Informed Consent Form
Project H.O.W., Health Outcomes of Women - Time 1

1. The purpose of this study is to find out HOW to help women become healthier. We want to identify ways to help women. We are looking at your total health and well-being. When the study is over, we will try to change things that you and the other women identify as important here in Dallas. We will also report the combined results from all women nationally, hoping that changes can be made elsewhere, too.

2. This study is being funded by the Centers for Disease Control and Prevention. It is being conducted jointly by Ms. Anne Freeman of the Dallas County Health Department and Dr. Linda Marshall of the University of North Texas, Psychology Department.

3. We are looking at HOW stress and life situations hurt and help women's health and well-being. This is the first of four interviews over the next two years to find out how your life changes and how it stays the same. It is very important that you complete all four interviews. You will be asked about how you have been thinking and feeling lately; relationships with friends and family; how you think about yourself, your self-concept; and how you cope with your problems, etc. The questions are about good things and bad things in your life.

4. Because we need personal information, we want to explain our procedures. The office workers will not know exactly what we ask or any of your answers. The interviewer will not know your full name. No one can connect your full name to the answers you give us unless you want us to, or unless Dr. Marshall does a follow-up study in several years. For your interviews, you will use a code. The project is covered by Certificates of Confidentiality so no one (including a court of law, the housing department, etc.) can find out what you say to us. We got the Certificates from the public because it is important that you answer our questions truthfully, even when doing so violates some rule (like if you make more money than you are supposed to). No one can learn anything about you from us. When we make reports, write articles, and give presentations, we will use only the combined answers from many women.

5. We need your help to keep the content of this study confidential. Please do not talk about specific questions we ask with anyone else, even the office worker or other women participating in this study. Some women could be hurt if people find out what questions we ask.

6. Besides keeping track of all the women who participate, our office workers will provide child care during interviews. As with anyone else in an "official" capacity (like teachers, doctors, etc.), we will report child abuse if we see evidence of it or are told about it. That is the ONLY exception to our rule of not telling anyone anything about individual women.

7. It may be difficult to answer some questions, use rating scales, or tell us things you have never told anyone else. You may feel frustrated, sad, offended or angry. These feelings should be temporary. On the other hand, the questions may help you in some way. You may come to think about yourself in a different way, even if the interview upset you.

8. The time you spend on the project will be compensated with a combination of cash, vouchers, and other goods. To show how valuable your time is and the increasing importance of what you tell us, we will give you more cash and gifts for each of the later interviews. To contact you for later interviews we may send postcards, call you and/or visit your home. We may try to find you through the people you give us. If you tell us when your address or telephone changes, we will not need to contact anyone else. These procedures are used because each woman is very important to us.

9. It is very important to us that you are treated well. If anyone on the project is impolite or unkind, please report it to Dr. Marshall (817-565-4329) or Ms. Anne Freeman (819-1900) at the Health Department. We want to make this experience as easy for you as possible. Also feel free to contact Ms. Deirdre Harris, 819-1930, if you have any ideas about making the project better for you.

10. Results of the study will be used to identify ways to more effectively help those of you who have problems that affect your health and well-being. We hope to be able to tell you some of the things we find out as we go along, but we will not be able to tell you everything about the study until it is over. A few months after the last set of interviews, we will have a series of meetings for women who participated. At that time we will answer all your questions and report our findings to you. While the study is going on, we will try to provide information that could help you as often as possible.

11. This study was approved by the University of North Texas Institutional Review Board for the Protection of Human Subjects in Research.

_____	_____
Ms. Anne C. Freeman	Dr. Linda L. Marshall

PROJECT HOW
Summary of Informed Consent

1. The purpose of the study is to find out how to help low income women become healthier. The results will help us make changes to serve you better.

2. The Centers for Disease Control and Prevention is funding the study. Dr. Linda L. Marshall from the University of North Texas and Ms. Anne C. Freeman from the Dallas County Health Department are directing the study.

3. We are looking at how stress and life situations hurt and help your health and well-being. You will be interviewed (in English) 4 times in the next 2 years so we can learn how women's lives change and how they stay the same in ways that affect their health. The first time you come may take about
3 hours for you to register, report the history of your health, and be interviewed. You will also have the opportunity to make suggestions to improve the project.

4. Procedures for confidentiality are very strict so you can feel safe answering questions truthfully. The office workers will not know the questions we ask or your answers. The interviewers will not know your full name or where you live. Certificates of Confidentiality protect you. No one (even a court of law) can ever find out what you tell us without your written permission.

5. Some women could be hurt if people learn about our questions. Please help us protect these women by not talking about specific questions asked during interviews. Do not even discuss it with others in the study or our office workers.

6. We will not ask questions about current or recent abuse of children. However, if the office worker notices abuse while she is providing child care during interviews, we will report it.

7. You may feel frustrated, sad, offended or angry during interviews. The feelings will be temporary and may cause you to see things in a new way.

8. It is important that you come for all 4 interviews. The gifts we give you will increase in value each time. We may contact you for later interviews through the mail, by telephone, in person, or (if necessary) through other people. You will tell us what is best for you.

9. If anyone on the project is impolite, unkind, or offensive in any way please contact Ms. Freeman or Dr. Marshall. Call Ms. Harris if you have ideas about making the project better.

10. After the project is over, we will have meetings to tell you everything we learned. In the meantime, we plan to provide you with useful information through our offices.

11. The procedures for this study were approved by the University of North Texas Institutional Review Board for the Protection of Human Subjects in Research.

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APPENDIX F

PERMISSION TO CONTACT AGENCIES OR DEPARTMENTS

PERMISSION TO CONTACT AGENCIES OR DEPARTMENTS

Project HOW is a study of Health Outcomes of Women sponsored by the Centers for Disease Control and Prevention and conducted by the University of North Texas and the Dallas County Health Department.

I, _____, give the departments and/or agencies I circled my permission to help Project HOW staff locate me in the future. The departments and/or agencies have permission to release my address and telephone number. This permission does not allow Project HOW staff to release any information about me to those departments and/or agencies.

Department of Health for WIC

other_____

Department of Human Services for AFDC Food Stamps

other_____

Parkland Hospital Dallas Housing Authority

Other_____

_____
signature

Project HOW
Permission to Contact Dallas Independent School District

Project HOW is a study of Health Outcomes of Women sponsored by the Centers for Disease Control and Prevention and conducted by the University of North Texas and the Dallas County Health Department.

I, _____, give the Dallas Independent School District my permission to help Project HOW staff locate me in the future. DISD has permission to release my address and telephone number. This permission does not allow Project HOW staff to release any information about me to DISD.

_____
Student's name; school in Spring, 1995; grade in Fall, 1995

_____
Student's name; school in Spring, 1995; grade in Fall, 1995

_____
Student's name; school in Spring, 1995; grade in Fall, 1995

_____
Student's name; school in Spring, 1995; grade in Fall, 1995

_____
signature

`

Project HOW
Permission to Contact People

Project HOW is a study of Health Outcomes of Women sponsored by the Centers for Disease Control and Prevention and conducted by the University of North Texas and the Dallas County Health Department.

I, _____, give the person named below my permission to help Project HOW staff locate me in the future. This person has permission to release my address and telephone number. This permission does not allow Project HOW staff to release any information about me to the person listed.

_____

name telephone

_____

address including apartment number and city if not Dallas

_____

new telephone

_____

new address including apartment # and city if not Dallas

_____

new telephone

_____

new address including apartment # and city if not Dallas

_____

signature

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APPENDIX G

SEVERITY OF VIOLENCE AGAINST WOMEN SCALE

SEVERITY OF VIOLENCE AGAINST WOMEN SCALE

never 0 1 2 3 4 5 a great many times

never 0 1 2 3 4 5 6 7 8 9 almost daily

Threats of Violence

1. Hit or kick a wall, door, or furniture
2. Throw, smash or break an object
3. Drive dangerously with you in the car
4. Throw an object at you
5. Shake a finger at you
6. Make threatening gestures or faces at you
7. Shake a fist at you
8. Act like a bully towards you
9. Destroy something belonging to you
10. Threaten to harm or damage things you cared about
11. Threaten to destroy property
12. Threaten to hurt someone you cared about
13. Threaten to hurt you
14. Threaten to kill himself
15. Threaten to kill you
16. Threaten you with a weapon
17. Threaten you with a club like object
18. Act like he wants to kill you
19. Threaten you with a knife or gun

Acts of Violence

20. Hold you down pinning you in place
21. Push or shove you
22. Grab you suddenly or forcefully
23. Shake or roughly handle you
24. Scratch you
25. Pull your hair
26. Twist your arm
27. Spank you
28. Bite you
29. Slap you with the palm of his hand
30. Slap you with the back of his hand
31. Slap you repeatedly around the face and head

32. Hit you with an object
33. Punch you
34. Kick you
35. Stomp on you
36. Choke you
37. Burn you with something
38. Use a club-like object on you
39. Beat you up
40. Use a knife or gun on you

Sexual aggression

41. Demand sex whether you want it of not
42. Make you have oral/mouth sex against your will
43. Make you have sexual intercourse against your will
44. Physically force you to have sex
45. Make you have anal/bottom sex against your will
46. Use an object on you in a sexual way

Marshall, L. L. (1992). Development of the Severity of Violence Against Women Scales. Journal of Family Violence, 7, 103-121.

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APPENDIX H

MP-HARM

MP-HARM

Never 0 1 2 3 4 5 6 7 8 9 almost daily

How often does he...

1. use money you need or keep money from you when you need it
2. act like you don't matter to him
3. act like he doesn't believe you
4. act like he knows you better than you know yourself
5. act like you can do what you want, but get upset if you do
6. act like there's something wrong with you mentally or emotionally
7. get angry or hurt when you didn't do something the way he wanted it done
8. act secretive or try to keep things from you
9. ignore your needs or what you want
10. argue about little things
11. blame you for making him angry or upset
12. accuse you of wanting to be with another man
13. check on you to see if you're doing what you said you'd be doing
14. criticize something you did well or discount it
15. do something that makes you feel small or less than what you were (like less smart, less competent, less attractive, less moral)
16. discourage you from having interests that he isn't part of
17. discourage you from having your own friends
18. try to keep you from seeing your friends or family
19. do or say something that harms your self-respect or your pride in yourself
20. encourage you to do something then somehow make it difficult to do
21. get angry or hurt if you talk to someone about him or your relationship
22. change how you feel, you mood (so you feel bad when you'd felt good or feel good when you felt bad)
23. ignore you, act like you're not there
24. tell you that your friends or family upset you
25. make you feel like nothing you say will have an effect on him
26. make you choose between something he wants and something you want or need
27. make you worry about whether you could take care of yourself
28. make you worry about your physical health and well-being
29. make you feel guilty about something you have done or have not done
30. make you feel ashamed of yourself
31. make you worry about your emotional health and well-being
32. make you feel like you have to fix something he did that turned out badly

33. make you feel like you can't keep up with changes in what he wants
34. point out that he's the only one who really understands you
35. put himself first, not seeming to care what you want
36. get you to question yourself, making you feel insecure or less confident
37. remind you of times he was right and you were wrong
38. say his actions (which hurt you) are good for you or will make you a better person
39. say something that makes you worry about whether you're going crazy
40. say or do something that makes you feel guilty
41. somehow talk you out of seeking help for your health
42. somehow keep you from sleeping when you're tired or eating when you're hungry
43. somehow make you feel worried or scared even if you're not sure why
44. somehow make it difficult for you to go somewhere or talk to someone
45. somehow keep you from having time for yourself
46. take advantage of you in some way
47. tease you in a way that embarrasses you
48. get upset when you did something he didn't know about
49. tell you the problems in your relationship are your fault
50. tell other people things that make you look bad
51. tell others that you have emotional problems or are crazy
52. tell you someone told him what you did or said when he wasn't around
53. tell you that your friends or family don't care about you
54. tell you what he likes about you then get upset about the same thing
55. tell you that something he did was your fault
56. check up on you
57. interrupt or sidetrack you when you're doing something important
58. avoid you
59. discourage you from talking to his family, friends or people he knows
60. discourage you from making new friends
61. try to keep you from showing what you feel
62. try to get you to apologize for something that wasn't your fault
63. try to find out things you don't want to tell him
64. try to convince you something was like he said when you know that isn't true
65. try to convince you not to talk to anyone about him or your relationship
66. try to get you to say you were wrong even if you think you were right
67. use an offensive or hurtful tone of voice with you
68. wear you down emotionally (like keep at you about something until you feel worn out)

Marshall, L. L., & Guarnaccia, C. (1998). Men's psychological-harm and abuse in relationships measure (MP-HARM): Overt and subtle psychological abuse. Unpublished Manuscript. University of North Texas.

APPENDIX I

CONFLICT TACTICS SCALE

CONFLICT TACTICS SCALE

0	1	2	3	4	5
never	once	a few times	several times	many times	a great many

1. threatened to hit or throw something at you
2. thrown or smashed or hit or kicked something
3. thrown something at you
4. pushed, grabbed or shoved you
5. slapped you
6. tried to hit you with an object
7. kicked, bit, or hit you
8. hit you with an object
9. choked you
10. threatened you with a knife or gun
11. used a knife or fired a gun

Original Conflict Tactics Scale

1. threw something at you
2. pushed, grabbed, or shoved you
3. slapped or spanked you
4. kicked, bit, hit you with a fist
5. hit or tried to hit you with something
6. beat you up
7. choked you
8. threatened you with gun or knife
9. used a gun or knife on you

Straus, M. A., & Gelles, R. J. (1990). Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. In M. A. Straus & R. J. Gelles (Eds.), Physical violence in American families: Risk factors and adaptations to violence in 8,145 families (pp.95-131). New Brunswick, NJ: Transaction Books.

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APPENDIX J

SEXUAL ASSAULT QUESTIONS

SEXUAL ASSAULT QUESTIONS

1. Has anyone besides a date or partner used a weapon of any kind to make you have sexual intercourse or any other sexual act

2. [other than that] has anyone besides a date or partner physically forced you to have sexual intercourse or any other sexual act

3. [other than that] has anyone besides a date or partner used threats of physical force to make you have sexual intercourse or any other sexual act

4. [other than that] has anyone besides a date or partner pressured, convinced, deceived or tricked you to have sexual intercourse or any other sexual act like touching or fondling

5. [other than that] has anyone besides a date or partner touched you or fondled you in a sexual way when you did not want them to

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APPENDIX K

LIFE ORIENTATION TEST

LIFE ORIENTATION TEST

1	2	3	4	5	6
strongly disagree					strongly agree

1. In uncertain times, I usually expect the best
2. * If something can go wrong for me, it will
3. I'm always optimistic about the future
4. * I hardly ever expect things to go my way
5. * I rarely count on good things happening to me
6. Overall, I expect more good things to happen to me than bad

Scheier, M. F., Carver, C. S., & Bridges, M. W. (1995). Distinquishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem): A reevaluation of the Life Orientation Test. Journal of Personality and Social Pscyhology, 67, 1063-1078.

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APPENDIX L

ROSENBERG SELF-ESTEEM MEASURE

ROSENBERG SELF-ESTEEM MEASURE

Completely false I'm never like this						Completely true exactly like me
1	2	3	4	5	6	7

1. On the whole, I am satisfied with myself
2. * At times I think I am no good at all
3. I feel that I have a number of good qualities
4. I am able to do things as well as most other people
5. * I feel I do not have much to be proud of
6. * I certainly feel useless at times
7. I feel that I am a person of worth, at least equal with others
8. * I wish I could have more respect for myself
9. * All in all, I am inclined to feel that I am a failure
10. I take a positive attitude toward myself

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

APPENDIX M

PRIVATE SELF-CONSCIOUSNESS SCALE

PRIVATE SELF-CONSCIOUSNESS SCALE

Completely false I'm never like this						Completely true exactly like me
1	2	3	4	5	6	7

1. I'm always trying to figure myself out
2. I'm constantly thinking about my reasons for doing things
3. I sometimes step back (in my mind) in order to examine myself from a distance
4. I think about myself a lot
5. I generally pay attention to my inner feelings
6. I'm quick to notice changes in my mood
7. * I never take a hard look at myself

Scheier, M. F., & Carver, C. S. (1985). The Self-Consciousness Scale: A revised version for use with general populations. Journal of Applied Social Psychology, 15, 687-699.

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APPENDIX N

SOCIAL SUPPORT QUESTIONS

SOCIAL SUPPORT QUESTIONS

How many people…

1. accept you totally, including both your worst and your best points
2. can you really count on to tell you, in a thoughtful manner, when you need to improve in some way
3. do you feel truly love and care about you
4. would help you with household tasks if you needed it
5. would help you with shopping or other errands if you needed it
6. would loan you money if you needed it
7. would help you in an emergency
8. would help you make a decision
9. can you talk to about casual things going on in your life
10. can you talk to about important things going on in your life
11. are so close they're like family but really aren't

Saunders, B. E., Arata, C. M., & Kilpatrick, D. G. (1990). Development of a crime-related post-traumatic stress disorder scale for women within the Symptom Checklist-90-Revised. Journal of Traumatic Stress, 3, 439-448.

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APPENDIX O

SILENCING THE SELF SUBSCALE

SILENCING THE SELF SUBSCALE

The original scale is denoted in parentheses, the modification in denoted by underlining.

1	2	3	4	5	6
strongly disagree					strongly agree

1. I don't speak my feelings in my (an intimate) relationship when I know they will cause disagreement.
2. * When (my partner's) others needs and feelings conflict with my own, I always state mine clearly.
3. Instead of risking confrontations in (close) my relationships, I would rather not rock the boat.
4. * I speak my feelings with (my partner) others, even when it leads to problems or disagreements.
5. When (my partner's) others' needs or opinions conflict with mine, rather than asserting my own point of view I usually end up agreeing with (him/her) them.
6. When it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway. (Original item).
7. I rarely express my anger at (those close to me) others.
8. I think it's better to keep my feelings to myself when they do conflict with (my partner) others.
9. I try to bury my feelings when I think they will cause trouble (in my close relationships) with others.

Jack, D. C. (1991). Silencing the self: Women and depression. Cambridge: Harvard University Press.

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APPENDIX P

COMMUNAL ORIENTATION SCALE

COMMUNAL ORIENTATION SCALE

The original scale is denoted in parentheses, the modification in denoted by underlining.

Completely false						Completely true
I'm never like this						exactly like me
1	2	3	4	5	6	7

1. I often go out of my way to help another person
2. When making a decision, I take other people's needs and feelings into account
3. When I have a need that others ignore, I'm hurt
4. * I don't consider myself to be a particularly helpful person
5. I expect people I know to be responsive to my needs and feelings
6. I believe people should go out of their way to be helpful
7. * <u>I think</u> (words added) people should keep their troubles to themselves
8. * I'm not especially sensitive to other people's feelings
9. * I don't especially enjoy (giving others aid) <u>trying to help others</u>
10. * I believe it's best not to get involved taking care of other people's personal needs
11. When people get emotionally upset, I tend to avoid them
12. I'm not the sort of person who often (comes to the aid of others) <u>tries to help others.</u>

Clark, M. S., Oullette, R., Powell, M. C., & Milberg, S. (1987). Recipients mood, relationship type, and helping. <u>Journal of Personality and Social Psychology, 53,</u> 94-103.

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APPENDIX Q

DYADIC TRUST SCALE

DYADIC TRUST SCALE

1	2	3	4	5	6
strongly disagree					strongly agree

Stem for these items was: My partner or Friends:

1. can be counted on to help women/me
2. * do not show enough consideration
3. are perfectly honest & truthful
4. * are primarily interested in their own welfare
5. * cannot be trusted at times
6. are truly sincere in their promises
7. treat women/me fairly and justly

Larzelere, R. E., & Huston, T. L. (1980). The Dyadic Trust Scale: Toward understanding interpersonal trust in close relationships. Journal of Marriage and the Family, 42, 595-604.

APPENDIX R

CONCERN FOR APPROPRIATENESS SCALE

CONCERN FOR APPROPRIATENESS SCALE

The original scale is denoted in parentheses, the modification in denoted by underlining.

Completely false						Completely true
I'm never like this						exactly like me
1	2	3	4	5	6	7

1. I tend to show different sides of myself to different people.
2. In different situations and with different people, I often act like very different persons.
3. Although I know myself, I find that others do not know me.
4. Different situations can make me behave like very different people.
5. Different people tend to have different impressions about the (kind) <u>type</u> of person I am
6. I'm not always the person I appear to be
7. I sometimes have the feeling that people don't know who I really am.

Lenox, R. D. & Wolfe, R. N. (1984). Revision of the Self-Monitoring Scale. <u>Journal of Personality and Social Psychology, 46,</u> 1349-1364.

`

APPENDIX S

NETWORK ORIENTATION SCALE

NETWORK ORIENTATION SCALE

The original scale is denoted in parentheses, the modification in denoted by underlining.

1	2	3	4	5	6
strongly disagree					strongly agree

1. Sometimes it is necessary to talk to someone about your problems
2. Friends often have good advice to give
3. I often get useful information from (other people) <u>others</u>
4. * People should keep their problems to themselves
5. It's easy for me to talk about personal and private matters
6. In the past, friends have really helped me out when I've had a problem
7. * You can never trust people to keep a secret
8. When a person gets upset they should talk it over with a friend
9. * Other people never understand my problems
10. Almost everyone knows someone they can trust with a personal secret
11. * If you can't figure out your problems, nobody can
12. * In the past, I have rarely found other people's opinions helpful when I have a problem
13. * It really helps when you are angry to tell a friend what happened
14. * Some things are too personal to talk to anyone about
15. * If you confide in other people, they will take advantage of you
16. It's ok to ask favors of people
17. * Even if I need something, I would hesitate to borrow it from someone
18. * You have to be careful who you tell personal things to

Vaux, A., Burda, P., & Stewart, D. (1986). Orientation toward utilization of support sources. <u>Journal of Community Psychology, 14,</u> 159-170.

`

APPENDIX T

SUICIDALITY MEASURE

SUICIDALITY MEASURE

The original scale is denoted in parentheses, the modification in denoted by underlining.

1	2	3	4	5	6	7
never			about half of the time			always

1. Felt that life is entirely hopeless
2. Felt that life isn't worth living
3. Thought of the possibility that you might (make) do away with yourself
4. Found yourself wishing you were dead and away from it all
5. Found that the idea of taking your own life kept coming into your mind

Goldberg, D. P., & Hillier, V. F. (1979). A scaled version of the General Health Questionnaire. Psychological Medicine, 9, 139-145.

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APPENDIX U

DISSOCIATIVE SCALE

DISSOCIATIVE SCALE

The original scale is denoted in parentheses, the modification in denoted by underlining.

0	1	2	3	4
not at all	a little bit	moderately	quite a bit	extremely

1. Feeling outside of your body
2. Daydreaming
3. Forgetfulness
4. No feeling like your real self
5. (Feeling "spaced out") Spacing out
6. Watching yourself from far away
7. Things feeling unreal
8. Your mind going blank
9. Feeling disconnected from yourself
10. Periods of memory loss
11. Losing touch with reality
12. Absent-mindedness
13. A feeling of being far away

Briere, J., & Runtz, M. (1990). Augmenting Hopkins SCL Scales to measure dissociative symptoms: Data from two nonclinical samples. Journal of Personality Assessment, 55, 376-379.

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Abney, V. D., & Priest, R. (1995). African Americans and sexual child abuse. In L. A. Fontes (Ed.), Sexual abuse in nine North American cultures (pp. 11-30). Thousand Oaks, CA: Sage.

Aguilar, R. J., & Nightingale, N. N. (1994). The impact of specific battering experiences on the self-esteem of abused women. Journal of Family Violence, 9, 35-45.

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American Psychological Association. (1993). Violence and youth. Washington DC: American Psychological Association.

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Anderson, T., Ogles, B. M., Weis, A. (1999). Creative use of interpersonal skills in building a therapeutic alliance. Journal of Constructivist Psychology, 12, 313-330.

Andersson, G. (1996). The benefits of optimism: A meta-analytic review of the Life Orientation Test. Personality and Individual Differences, 21, 719-725.

Antonucci, T. C., & Israel, B. A. (1986). Veridicality of social support: A comparison of principal and network members' responses. Journal of Consulting and Clinical Psychology, 54, 432-437.

Arata, C. M. (1999). Coping with rape: The roles of prior sexual abuse and attributions of blame. Journal of Interpersonal Violence, 14, 62-78.

Arata, C. M., & Burkhart, B. R. (1998). Coping appraisals and adjustment to nonstranger sexual assault. Violence Against Women, 4, 224-239.

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